AFG05

MINISTRY OF HEALTH
MANAGEMENT SCIENCES FOR HEALTH
KABUL, AFGHANISTAN

تیم منجمنت
وزارت صحیه
کابل - افغانستان

MANAGEMENT SUPPORT FOR RURAL AND FAMILY HEALTH SERVICES
A PROJECT OF THE MINISTRY OF PUBLIC HEALTH, REPUBLIC OF AFGHANISTAN

INITIAL ANALYSIS AND WORK PLAN
MARCH 1974 (HOOT, 1352)

A NON-PROFIT INSTITUTION

ONE BROADWAY, CAMBRIDGE, MASSACHUSETTS 02142
CABLE: MANSHEALTH (617) 661-9450

MANAGEMENT SCIENCES FOR HEALTH
A NONPROFIT INSTITUTION

MANAGEMENT SUPPORT FOR RURAL AND FAMILY HEALTH SERVICES

A PROJECT OF THE MINISTRY OF PUBLIC HEALTH,

REPUBLIC OF AFGHANISTAN

INITIAL ANALYSIS AND WORK PLAN

MARCH 1974 (HOOT, 1352)

Table of Contents — Page

ONE BROADWAY, CAMBRIDGE, MASSACHUSETTS 02142
CABLE: MANSHEALTH (617) 661-9450

ABBREVIATIONS

AID	Agency for International Development
BHS	Basic Health Services - Rural and Family Health
GMD	General Medical Depot
MOF	Ministry of Finance
MOP	Ministry of Planning
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
PFO	Provincial Finance Office
PHI	Public Health Institute
PHO	Provincial Health Officer
RGOA	Republican Government of Afghanistan
TEMO	Transport and Equipment Maintenance Organization
UNICEF	United Nations Children's Fund
WFO	Woleswali Finance Office
WFP	World Food Program
WHO	World Health Organization

PREFACE

This working paper summarizes the initial impressions of the MSH Management Team and outlines a cooperative plan of work of the Ministry of Public Health under an agreement between the Government of Afghanistan and USAID.

MSH owes a great debt to our colleagues in the MOPH, who under the guidance of the Minister, have consistently and generously given of their time and experience to help the Team become familiar with MOPH activities.

This paper is composed of two kinds of information: statements of fact and analyses of those facts, derived from interaction with our MOPH colleagues. Inevitably, our understanding of the facts, and the related analysis, contains errors. We earnestly seek comments, corrections and clarification from our MOPH colleagues to improve our understanding of the facts and thereby our usefulness to the MOPH effort.

We are, and will continue to be, indebted to our other colleagues working with the MOPH who work with us on a daily basis and who welcomed us to the fold. Dr. Beyhum, WHO Representative and his staff, and Mr. Svend Hoelgaard, UNICEF Representative with Mr. and Mrs. Paul Kesterton, UNICEF Field Program Officers, form an extended family on which the Management Team depends quite heavily.

A GUIDE TO THE USE OF THIS REPORT

To utilize this report efficiently:

The reader who is well acquainted with Afghan Health Activities may want to review:

Section 1	The Initial Management perspective
Section 4	Rationale for Work Strategy, and Summary of Priorities
Section 5	The Work Plan

With a selective review of the other detailed sections as indicated.

The reader with less familiarity with Afghan Health Activities may want to also include:

Section 2	The Health System in Afghanistan
Section 3	MOPH Administrative Operations

1. RURAL AND FAMILY HEALTH SERVICES IN AFGHANISTAN

March 74

An Initial Management Perspective

1.1 INTRODUCTION

Afghanistan is fortunate that at least three types of information are becoming available to provide an initial overview of the health scene. These include:

a) Rural Village Studies[1]: To determine which health problems the Afghan people feel are important, and which are not felt to be important.

b) Epidemiologic and Vital Data Surveys[2]: To determine the distributions of people, health problems and disease in Afghanistan.

c) Health Resource Reports[3]: To determine what facilities and services are available, as well as what problems, and which people, come to health facilities.

This section contains a brief review of the issues raised by Ministry of Public Health (MOPH) decision-makers, documented by the above information sources and by the Management Team itself. It deals specifically with:

a) The Social Environment - How Afghans look at and react to health problems.

b) The Health Setting and Health System - Existing health problems and resources in Afghanistan.

1.2 THE SOCIAL ENVIRONMENT - How Afghans View Health Problems

Rural social studies such as those recently completed by the government and UNICEF are invaluable for understanding Afghan perceptions of their needs. They suggest that:

a) In rural public life males dominate, while females remain in the home;

b) At present, rural Afghans have very limited experience with government-supported social services, with health services representing a recent visible government initiative to serve the people;

c) Cultural, class, language, sex and age differences between villagers on the one hand and urban-trained physicians and some other health workers on the other, inhibit the development of the trusting relationships associated with effective health service.

d) Villagers are apt to use several systems of medical care for serious illnesses, often frustrating the scientific approach to diagnosis and therapy.

e) It is extremely important to note that rural perceptions of serious health problems appear to differ sharply from those common to modern scientific medicine, and most importantly, from an epidemiologic catalog of the health problems that exist in Afghanistan.

1. RURAL AND FAMILY HEALTH SERVICES: Social Environment March 74

A recent major study supported by the Ministries of Planning and Health[1] points out that the health problems most feared in rural areas include:

child mortality
difficult labor and maternal mortality
smallpox
sterility

The same study suggests that some health problems are often accepted as part of life once acute symptoms are relieved, including:

malaria
malnutrition
problems of sanitation (commonly manifested as diarrhea)
chronic infectious illnesses (such as tuberculosis)

1.3 THE HEALTH SETTING AND HEALTH SYSTEM - Existing Problems and Resources

Epidemiologic and Vital Data Surveys and Health Facility Reports are extremely useful aids in understanding the Health Setting and Health Systems. They suggest that:

a) The people have many infectious and epidemic disease problems, with notably high mortality among infants and mothers.

b) There is an important mismatch between problems and public health resources. That is, although women and children are more often seriously ill and require more preventive care than males, clinic attendance ratios of adult men to adult women to children under 15 are often 2:1:1; that is, of every 100 visits, 50 are by men, 25 by women and 25 by children.

c) In the experience of good rural Afghan health facilities[2], patients present themselves for care with the following problems:

Respiratory diseases (including TB 10%).	40%
Intestinal infection	20%
Skin conditions (including leprosy).	10%
Other infectious diseases (measles, typhus, chickenpox, etc.).	5%
Parasitic disease (helminths, malaria, etc). . .	5%
Traumatic and orthopedic disease	10%
Unspecified (incl. obstetric, malnutrition,etc.)	10%

d) A number of the diseases common in developed countries, including diseases of the heart, blood vessels, and cancer, are not commonly seen in Afghanistan.

e) For reasons of access (such as proximity to village life, cost, social barriers), habit and availability, rural health activity is more likely to be provided by traditional healers, midwives, itinerant dispensers, bazaar merchants and small pharmacies than by health centers, sub-centers, private physicians and hospitals.

f) While the MOPH health budget provides approximately 24 Afs. ($.40 US, 1974) per person per year, at present only a small percentage of the population is being reached except by vertical programs such as smallpox, and the effective amount spent for each person actually served may be 5 to 10 times the general per capita figure, or 120 to 240 Afs. per year. Of equal significance is that the total national health investment, including a conservatively estimated private sector expenditure on drugs and services as well as international and bilateral assistance, is at least 4 to 5 times the direct MOPH budget. (See Appendix 4.)

g) The MOPH network of health center services extends to the woleswali (district) level. Approximately 100 of 180 planned basic health centers are now operational. Their mission is to provide preventive and simple curative care, as well as to screen and refer more complex problems to provincial hospitals. Each health

center is under the general guidance (and occasionally strict control) of the health center physician, although other health team members - nurses, midwives, compounders, sanitarians and vaccinators - often diagnose problems and provide treatment. While government facilities theoretically provide free service, in practice the system is partly on a fee-for-service basis. Most health centers reach only a small proportion, perhaps 5%, of the population.

h) At present, the major activity of traditional healers, pharmacies, health centers and hospitals is focused on curative medicine for acute problems.

i) Evidence from well-documented rural centers suggests that as patients become aware of and accustomed to a responsive facility, the percentage of visits for minor conditions expands rapidly - from 12% to 30% over a one year period in one example[2]. This suggests that the priority functions of the health center system may be easily displaced if clear policies and procedures are not enforced.

j) Centrally directed, staffed and managed mass campaigns have been used successfully against smallpox, and unsuccessfully against malaria, the latter effort consuming about 20% of the national operating health budget for services for a number of years.

k) 540 to 600 pharmacies, both government and private, provide access to medication for the people, without restriction by physician prescription. Drugs, initially purchased by Afghanistan almost entirely in scarce hard currency exchange, account for an annual expenditure equal roughly to the rest of the development and operating budget for the entire Ministry.

1.4 INTERPRETATION AND OPINION OF THE TEAM

Initial fact finding and analysis suggests that:

a) The Government budget for health is likely to remain severely limited; access to preventive and curative health care cannot be directly provided by government facilities to all the people throughout the country, and particularly to rural areas;

b) Without clear policy and program direction, enormous amounts of money from the limited government budget can easily be consumed in the remedy of self-limited illness, thereby diverting available health resources - money, facilities, and workers - from tasks that can produce higher payoff for the people;

c) Priorities must be set, combining both the expressed needs of the Afghan people and the technical abilities of the health services to act effectively on these needs. For example, committing large amounts of resources for many years into activities such as a Malaria Eradication Program, which may not be technically feasible within foreseeable economic constraints, may well be less productive than alternative programs which will produce desired results.

1.5 IMPLICATIONS FOR ACTION

In view of these facts and our interpretation of their consequences, the Management Team is encouraged that the MOPH is expressing priority interest in both of the following:

1.5.1 Effective Management of Existing MOPH Resources within the current program

This would be assisted through:

a) Institution of efficient management procedures for public health operations;

b) Training auxiliary health workers;

c) Consideration of using existing health workers from categorical programs such as malaria and smallpox for wider duties;

d) Institution of specific task and work program assignments for all Basic Health Center staff;

e) Emphasis on family health and the services that impact directly on mothers and children, as the group that has the greatest health problems and stands to gain the most.

1.5.2 Consideration of new initiatives to realistically extend available health services in rural areas either directly through government channels or through complementary resources.

An important set of examples is encompassed by the serious consideration of alternatives for innovative drug use in Afghanistan, particularly in terms of:

a) National formulary limitation,

b) Generic drug purchasing and/or production,

c) Simple, practical packaging of drugs for widespread dispensing by available rural personnel;

d) Practical guidelines for drug use for workers with rural skill levels.

We believe it is important that these MOPH initiatives be clearly recognized, respected, and responded to. This project - Management Support for Rural and Family Health Services - can be most helpful by working with MOPH leaders to support their decisions affecting both:

- efficient use of existing MOPH resources, and
- analysis of new initiatives to encourage extension of available health care through channels that are complementary to direct MOPH activities.

The balance of this report includes:

Section 2	An Overview of the Health System
Section 3	An Analysis of MOPH Administrative Operations
Section 4	A Summary of Priorities and Rationale for the Plan Action
Section 5	The MOPH/Management Team Work Plan

REFERENCES

---

1. Services for Children within Regional Development Zones, CINAM/ UNICEF, Kabul, 1973, Volumes I, II, III.

2. Epidemiologic and Vital Event Surveys:

   a. Buck, A. Health and Disease in Rural Afghanistan, York Press, Baltimore, 1972.

   b. Fisher, L., Afghanistan/A Geomedical Monograph, Springer-Verlag, Berlin, 1968.

   c. Afghan Demographic Studies Sample Surveys, Ministry of Planning, Government of Afghanistan, Kabul, in process,

3. Health Resource Reports

   a. Quarterly Statistical Reports, Department of Planning, MOPH.

   b. Annual Report, Medical Assistance Program to Afghanistan, Kabul, 1973.

   c. The Basic Assistance List, Planning Board, MOPH, Kabul.

2. THE HEALTH SYSTEM IN AFGHANISTAN

2.1 Sources of Health Services
- 2.1.1 Non-Governmental
- 2.1.2 Governmental
- 2.1.3 Health Services by Location

2.2 Organization of Government Health Services
- 2.2.1 Central MOPH Organization - General Overview
- 2.2.2 Key Health
  - 2.2.2.1 Preventive Medicine
  - 2.2.2.2 Administration
  - 2.2.2.3 Planning
  - 2.2.2.3 Planning
  - 2.2.2.4 Inspection
  - 2.2.2.5 Technical Board
  - 2.2.2.6 Public Health Institute
- 2.2.3 Intermediate Levels of Supervision and Control
  - 2.2.3.1 Regional
  - 2.2.3.2 Provincial
- 2.2.4 Relative Weighting of MOPH Organizational Units
- 2.2.5 Location of MOPH Activities

2.3 Focus on Rural and Family Health Services - The Basic Health Center Program
- 2.3.1 Objectives
- 2.3.2 Organization and Control
- 2.3.3 Staffing
- 2.3.4 Location
- 2.3.5 Materials and Equipment
- 2.3.6 Centralized Clinic Orientation
- 2.3.7 Curative Orientation
- 2.3.8 Family Health
- 2.3.9 Analysis and Summary of Opportunities
  - 2.3.9.1 Training and Attitudes of the Doctors
  - 2.3.9.2 Job Descriptions and Division of Responsibilities
  - 2.3.9.3 Technical and Administrative Supervision
  - 2.3.9.4 Basic Supporting Medicines and Equipment
  - 2.3.9.5 Female Staff Members
  - 2.3.9.6 Personnel Posting to Health Centers
  - 2.3.9.7 Rural Confidence in Modern Medicines and Reliance on Rural Remedies and Healers
  - 2.3.9.8 Health Education

2.4 Summary of Rural Health Service Problems and Actions that can Contribute to Solutions

FIGURE 2.1

HEALTH SERVICES AVAILABLE FROM PUBLIC & PRIVATE SOURCES

	Ministry of Health	Private & Voluntary Agencies	Physicians and the Private Sector
CAPITAL	Hospitals (11) Urban Health Centers (12) (from Red Crescent Society and Rozan-toon)	Red Crescent Hospital (1) AFGA Clinics (6) Noor Eye Clinic (1)	Doctors (500)[1] (1:2,000 population)[2] Private Clinics Pharmacies (125) (1:8,000 population) Practitioners & Dias
REGIONAL (5)	Smallpox Vaccination & Malaria Surveil-lance Unit		
PROVINCIAL CENTERS (28)	Hospitals (approx. two per province); some with MCH centers	AFGA Clinics (10) Noor Eye Clinic (1)	Doctors (700)[1] Pharmacies (315)[3] (1:50,000 pop.) Practitioners, Dias & Merchants
WOLESWALI TOWNS (178)	Basic Health Centers (102) Periodic Smallpox & Malaria Surveillance	Red Crescent Hospital (1)	Doctors[1] Pharmacies[3] Practitioners, Dias & Merchants
VILLAGES (16,000)	Sub Centers (74) (Private Practice Periodic Smallpox & Malaria Surveillance		Pharmacies[3] Practitioners, Dias & Merchants & Variolators [4]

1. Assumes 500 Doctors in Kabul and 700 in the rest of the country; total 1,200, working in both public and private practices.
2. Assumes 1 million population in Kabul and 16 million in the rest of the country.
3. Approx. 315 pharmacies at Provincial, Woleswali and Village level.
4. If there are 2 local health sources in each village, total 32,000.

2. THE HEALTH SYSTEM IN AFGHANISTAN

March 1974

2.1 SOURCES OF HEALTH SERVICES

The existing system of health services includes components directly available through non-governmental channels and from governmental sources.

2.1.1 Health Services from Non-Governmental Sources

For reasons of access and availability, it is probable that Afghans seek assistance for the majority of their health problems from sources outside the present formal government structure. These sources include:

a) Village Practitioners: females, such as dais; males, such as village leaders, mullahs, and teachers. Some of these practitioners had health exposure through government military service or vaccination teams. Some are itinerant injectionists and vaccinators (variolators);

b) Bazaar merchants and pharmacy operators;

c) Private physicians;

d) Voluntary and semi-private agencies such as the Red Crescent Society, AFGA and NOOR, which operate clinics directed at specific groups or areas;

e) Industrial organizations with services for employees, such as the Spinzar Cotton Company.

2.1.2 Health Services from Governmental Sources

Beyond its policy making and planning function for all aspects of health, the Government directly provides services through the operation of:

a) Hospitals: the MOPH providing services for the general public, while other ministries (including Defense, Education, and Mines and Industries) provide coverage for their employees;

b) Ambulatory Care: hospital outpatient departments, health centers separate from hospitals, mobile teams for malaria surveillance and smallpox and BCG immunization;

c) Environmental Health Programs: water supply, waste disposal, hygiene education, and insect vector control;

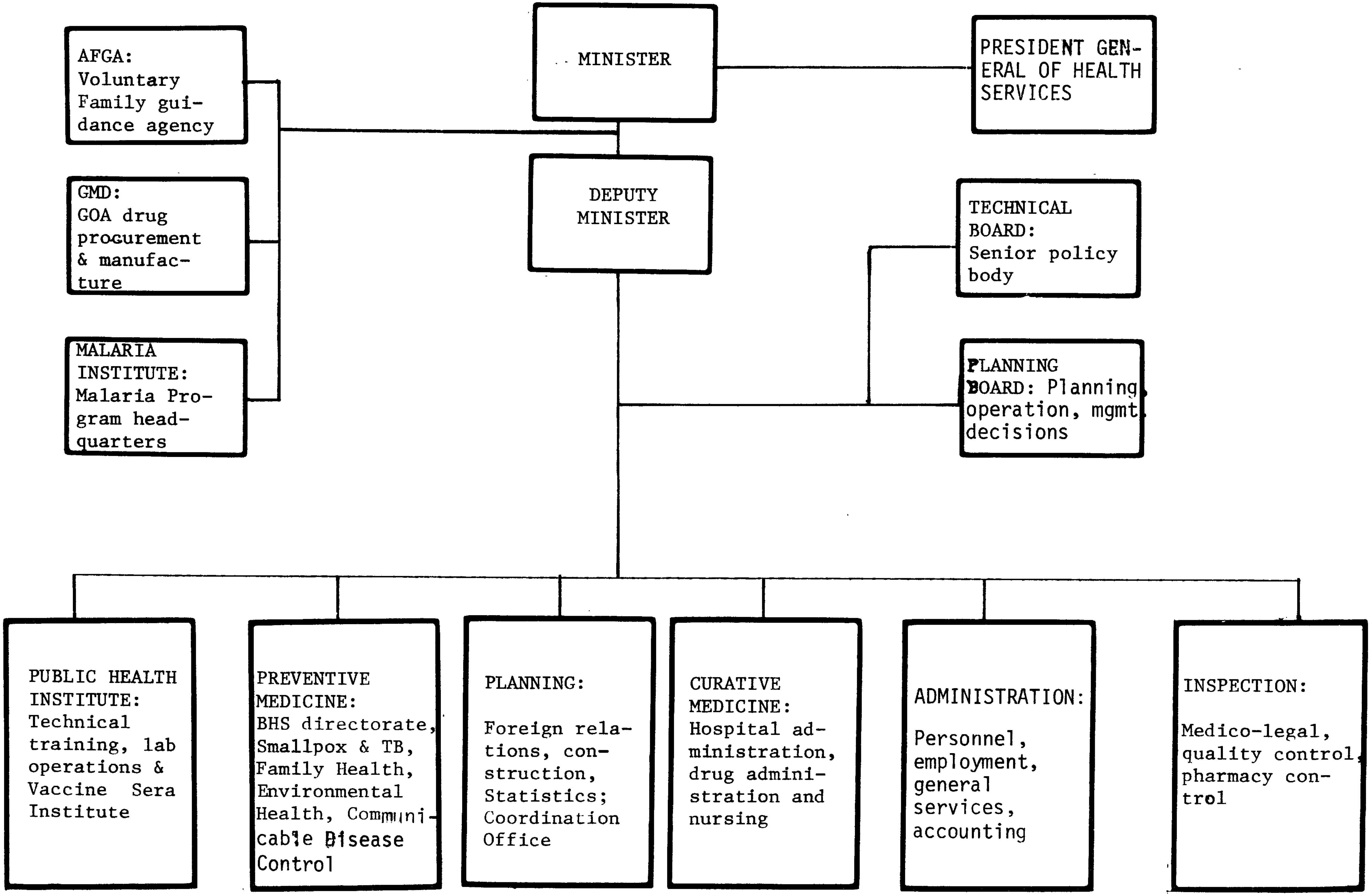
d) Facilities for the control and production of drugs and vaccines as well as some laboratory functions.

2.1.3 Health Services by Location

Figure 2.1 presents a schematic view of the sources of health service by location, and begins to suggest the disparity and distance between the rural population and health services available through Government facilities. Of particular note are the differences between the large number of pharmacies and the few health centers in Woleswali towns, and the even more marked differential between the probable number of village practitioners and the government health facilities.

FIGURE 2.2

ORGANIZATIONAL STRUCTURE OF MINISTRY OF PUBLIC HEALTH



2.2 THE HEALTH SYSTEM: ORGANIZATION OF GOVERNMENT SERVICES

2.2 ORGANIZATION OF GOVERNMENT HEALTH SERVICES

The MOPH is the primary focus for health planning, health policy and health services. The MOPH organizational structure is outlined in Figure 2.2, with areas of functional responsibility noted.

2.2.1 Central MOPH Organization - General Overview

The major organizational units functioning actively within the Ministry include its five departments and the Public Health Institute, which has departmental status as noted in Figure 2.2. The major "field" programs (i.e. those that deliver services at the local level) are the Basic Health Service System, the Malaria and Small Pox Programs, and to a lesser extent, small scale curative facilities.

As Figure 2.2 indicates, the Deputy Minister and the special Advisor (General President for Health Services) support the Minister in the overall administration of the health system, including presiding over the Technical and Planning Boards. Three important agencies connected with the MOPH - the Malaria Institute, the General Medical Depot (GMD) which is responsible for procurement of drug supplies, and the Family Guidance Association (AFGA) - have a great degree of autonomy. It might be said that these programs are directed by the Minister but not by the Ministry. The staff of these agencies are all direct civil service employees of the MOPH with the exception of some staff members of AFGA; they all have their own facilities physically separated from the rest of the MOPH, have control over their own vehicles, administrative system, and in the case of the Malaria Institute and AFGA, derive a large percentage of their funds directly from foreign donors.

2.2 THE HEALTH SYSTEM: ORGANIZATION OF GOVERNMENT SERVICES

Central MOPH Organization - Departments which influence Rural Health Care Activity

2.2.2.1 Curative Medicine Department

This department has primary responsibility for operation of 11 hospitals in Kabul province, of all hospitals in provincial centers, as well as the small (5 - 10 bed) hospitals in rural areas. This department also has a critical role in the process of drug procurement and allocations for the entire MOPH. The Department has overall responsibility for the training of nurses and for their technical support in the field.

2.2.2.2 Department of Preventive Medicine

As indicated in Figure 2.2, the Preventive Medical Department, headed by a president, encompasses communicable disease control, smallpox, TB, environmental health, family health, and the basic health center directorate. This department is thus presently responsible for two of the three major field programs - Small Pox and the Basic Health Services, but not for the Malaria Program. The Basic Health System is described in Section 2.3.

2.2.2.3 Department of Administration

This department includes separate bureaus responsible for personnel, supply, accounts, budget, and archives, and has become the focus of virtually all information, activities and decision-making of an administrative nature in the Ministry. Other departments play only a passive role, taking no responsibility for even routine administra-

tion. Changes following the founding of the Republic seem to indicate a trend toward some decentralization of administrative information and decision-making among Ministry departments.

The three field activities currently active - basic health services, smallpox and malaria - present a spectrum of degree of involvement with the Administration Department, ranging respectively from total dependence to near independence.

The BHC Bureau is almost totally dependent on the Administrative Department and others for the execution of basic support functions. The other bureaus of the Preventive Medicine Department have a similar relationship with Administration. For example, recruitment and posting of staff is handled entirely by the Administrative Department on the advice of the Transfer Committee. The BHC director is not informed by the Administration Department of staff levels, vacancies, or changes in the staffing of health centers. The BHC director plays little role in the formulation of the budget or in financial transfers. He has little influence on the procurement of supplies and equipment, though his staff have begun to play a greater role in the distribution process.

The Smallpox Program, although relatively autonomous in many ways, is much more a part of present MOPH operations than is Malaria. However, since the Smallpox Program receives virtually all of its equipment, per diem supplies, and vehicles from foreign donors, the Administrative Department budgets and pays only for salaries, travel and such minor items as stationery. The program also actively

recruits, trains, and posts its own personnel, communicating with, but largely independent of, Administrative Department control. Transfer of funds to the field does require the active participation and approval of the Ministry. Located well down in the MOPH chain of command, the Smallpox Director technically does not report directly to the Minister.

Except at budget time, the Malaria Program operates almost independently of the MOPH, including the Administrative Department, though Administration does participate in senior personnel transactions. Nearly all supplies and equipment come directly from foreign donors, and they take care of their own personnel recruitment and training. The fact that the program derives nearly as much financial support from outside sources as from the Afghan Government strongly supports this autonomy.

2.2.2.4 Department of Planning

Up to this time, this Department has not been in a position to do very much in financial, manpower, or facilities planning, though the department did play a role in formulating the health sector of the nation's five-year development plan. To date, the principal activities of the department have been in statistics, foreign relations, and construction, each represented by a Bureau. Planning has been under the direction of a number of different Presidents over the past several years, and there have been periods when the department had no President.

2.2 THE HEALTH SYSTEM: ORGANIZATION OF GOVERNMENT SERVICES

Although the Department has had little impact on rural health to date, a proposal is now being considered by the Ministry leadership which could create a meaningful planning function for the MOPH, including the BHCS. This proposal envisions the revitalization of the Planning Board, along with the development of supporting planning personnel within the Planning Department to act as the staff section of the Planning Board. The Board would be invested with policy-making authority in the areas of planning and management. The implications for rural health are considerable.

2.2.2.5 Department of Inspection

With broad responsibilities for review of licensure, the Department of Inspection plays an important and unappreciated role in rural health activities. Two functions are of particular interest.

a) Regulation of drug distribution: Pharmaceutical manufacturers must obtain Inspection Department approval prior to marketing specific drugs, an obviously important mechanism for controlling which drugs are allowed to reach the consumers.

b) Licensure of pharmacies and pharmacists: The number, location, operating procedures, and pricing structure of pharmacies, as well as the qualifications of pharmacists, are under the jurisdiction of the Inspection Department. With the exception of private practitioners, the number of pharmacies (over 500) is greater than all other health service outlets put together. With relatively close contact with the people by virtue of long operating hours and market place location, the pharmacy system

may well be the most important and easily exploitable Afghan health resource at this point in time, and will receive close attention in developing complementary strategies for the improvement of rural health services.

2.2.2.6 Technical Board

The Technical Board of the MOPH meets approximately every two weeks under the chairmanship of either the Minister, his deputy, or his special advisor. It is basically a policy review body and discussion forum, composed of department heads, heads of larger curative facilities and other senior MOPH staff, depending on the agenda. It is the only formal policy review mechanism currently operating in the Ministry.

2.2.2.7 Public Health Institute

Among its services, the PHI provides most of the basic training of technical personnel for Basic Health Centers.

2.2.3 MOPH Organization - Intermediate Levels of Supervision and Control

2.2.3.1 Regional Administration

There is a general Governmental trend toward developing more decentralized management structure for government programs. The Smallpox and Malaria Programs have a tradition of regional planning and control, and Basic Health Services have recently instituted regional physician supervision, although this is still in the

FIGURE 2.3

RELATIVE WEIGHTING OF MOPH ACTIVITY IN TERMS OF
STAFF & BUDGET, BY PERCENT OF TOTAL 1353 (MARCH '73-'74)

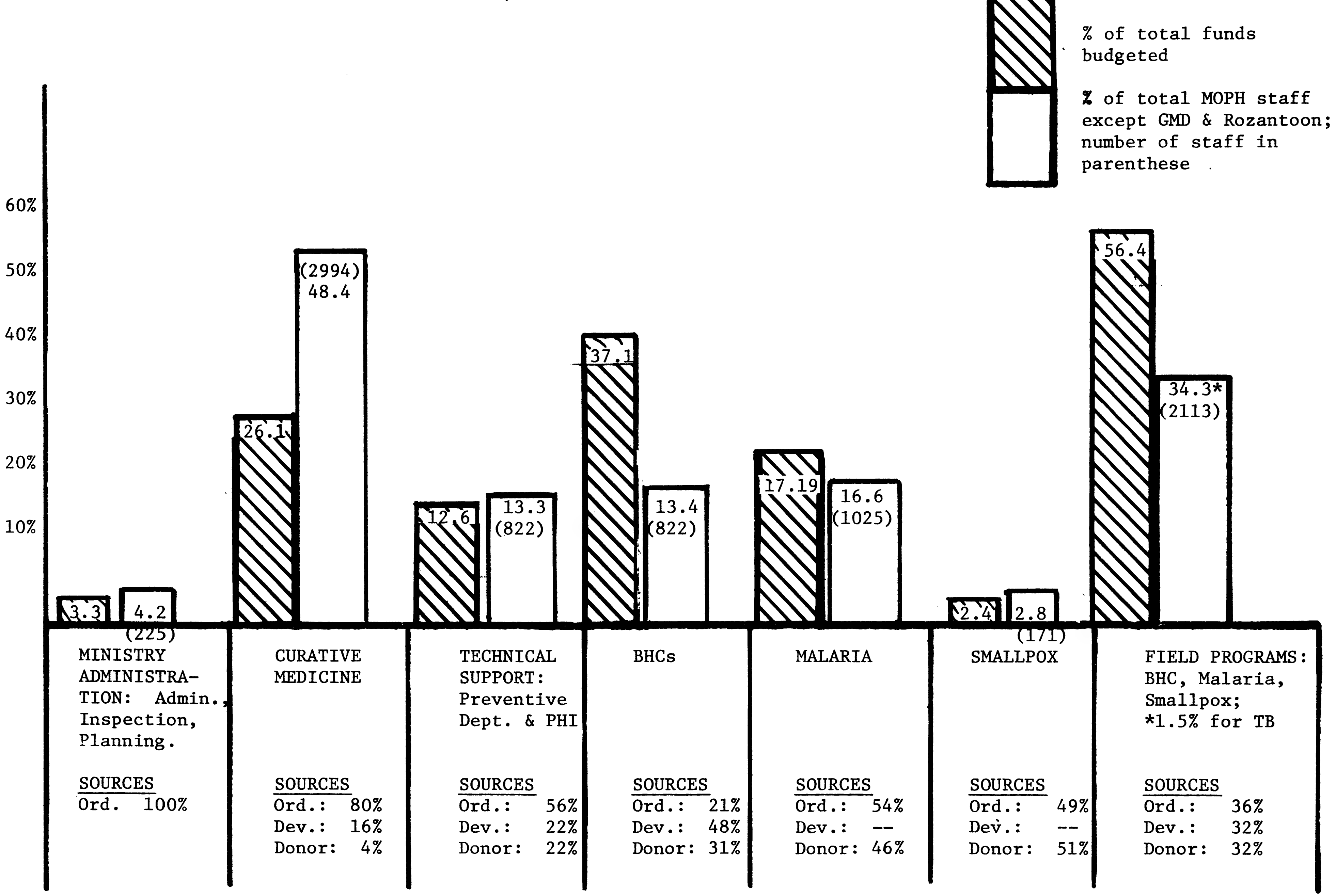


FIGURE 2.4

TOTAL INCOME BUDGETED FOR MOPH ACTIVITIES FOR 1352 (MARCH '73 - '74)
IN AFGHANIS - EXCHANGE ROUGHLY AFS. 60 = $1

MINISTRY ACTIVITY	ORDINARY BUDGET	% of to-tal	DEVELOPMENT BUDGET	% of to-tal	DONOR CONTRIBUTIONS	% of to-tal	TOTAL AMOUNT BUDGETED	% of to-tal	PERCENT OF TO-TAL MOPH STAFF
1. Ministry Administration	13,070,223	6.5%	-	-	-	-	13,070,223		4.2%
2. Curative Medicine Department	82,054,495	41%	16,000,000	14%	4,530,000	5%	102,584,495	26%	48.4%
3. Field Programs:									
BHC's	30,163,140	15%	70,000,000	63%	45,300,000	47%	145,463,140	37%	13.4%
Malaria	36,000,000	18%	-		30,600,000	32%	66,600,000	17%	16.6%
Smallpox	4,692,980	2.3%	-		4,800,000	5%	9,492,980	2.4%	2.8%
Rozantoon	6,475,655	3.2%	-		-		6,475,655	1.6%	-
Sub-Total	77,331,775	38.5%	70,000,000	63%	80,700,00	84%	228,031,775	58%	34.3%*
4. Technical Support	27,543,507	14%	11,000,000	10%	11,053,200	11%	49,596,707	12.6%	13.3%
TOTALS	200,000,000	100%	97,000,000 +15,000,000 (10 M. for vaccine/Sera Institute; 5 M. for workshop/warehouse)	87%	6,283,200	100%	393,283,200	100%	100.0% * Includes 1.5% for TB

developmental stage in terms of division of responsibility and authority.

2.2.3.2 Provincial Administration

The MOPH has traditionally been represented at the provincial level by a Provincial Health Officer (PHO). The PHO is under the general administrative control of the provincial governor; however, as chief health official of the province, the PHO looks to the MOPH for most administrative (and technical) direction, as well as for rewards and career pattern. In most cases, the PHO acts as the technical and administrative director of the provincial hospital. The demands of his job, coupled with the possibilities of supplementary income in the provincial capital, make it difficult and unlikely for PHO's properly to administer and to supervise rural health activities at the woleswali (county) and alakadari (sub-county) levels. Neither Smallpox nor Malaria are organized along provincial lines and the PHO has little responsibility and authority for supervising their activities.

2.2.4 Relative Weighting of Organizational Units of the MOPH

Rough but useful measures of MOPH actions to date are reflected in the relative weighting of organizational units, as depicted in terms of personnel and budget in Figure 2.3, and the budget summary in Figure 2.4. These illustrate the major emphasis placed on malaria, curative hospital-based services, smallpox and the development of basic rural health services.

FIGURE 2.5

STAFFING AND MOPH HEALTH PROGRAMS BY LOCATION

	GENERAL MOPH PROGRAM	MALARIA PROGRAM	SMALLPOX PROGRAM	BASIC HEALTH SERVICES PROGRAM
CAPITAL	Headquarters Staff (see Personnel Section) Curative Headquarters Staff (20) Hospital Staff (1064)	Malaria Institute (65)	Headquarters Staff (8)	BHC's Director, Supervisors, and Staff (14)
REGIONS (5)	Regional Staff (under discussion)	5 Regional Offices (79)	3 Zonal Offices (19) 5 Surveillance Teams (35) 3 Assessment Teams (15) 13 Vaccination Teams (104)	
PROVINCES (28)	Supervisory Teams Hospital Staff (1910)	28 Malaria Unit Units, each with several supervisory areas (3 - 7 per unit) (283)	Teams work at this level	P.H.O. (28) (No effective supervisory role)
WOLESWALIS (178) AND VILLAGES (16,300)		Surveillance Agents (598), average 26 per unit. Spray Teams (3 months only)	Teams work at this level	Health Centers (95) Sub-Centers (74) (Average 6 trained staff per Health Center and associated sub-centers)

2.2.5 Location of MOPH Activities

Another important dimension of the MOPH program is the location of government health services staff, outlined in Figure 2.5. This emphasizes that at the rural level, at present, there are only three channels of direct MOPH intervention:

a) The health center, with staff responsible for general curative and preventive work for the woleswali;

b) The smallpox teams, regionally based, and which at present make only infrequent sweeps through each woleswali;

c) The malaria surveillance agent, should the area have one, with responsibility for monthly visits to every house in every village in his area, looking for fever cases and giving treatment.

These MOPH-supported resources are augmented by the large pool of MOPH-regulated pharmacies, which require very little of the MOPH budget, but have a potentially large impact on available health services.

2.3 FOCUS ON RURAL AND FAMILY HEALTH SERVICES - THE BASIC HEALTH CENTER PROGRAM

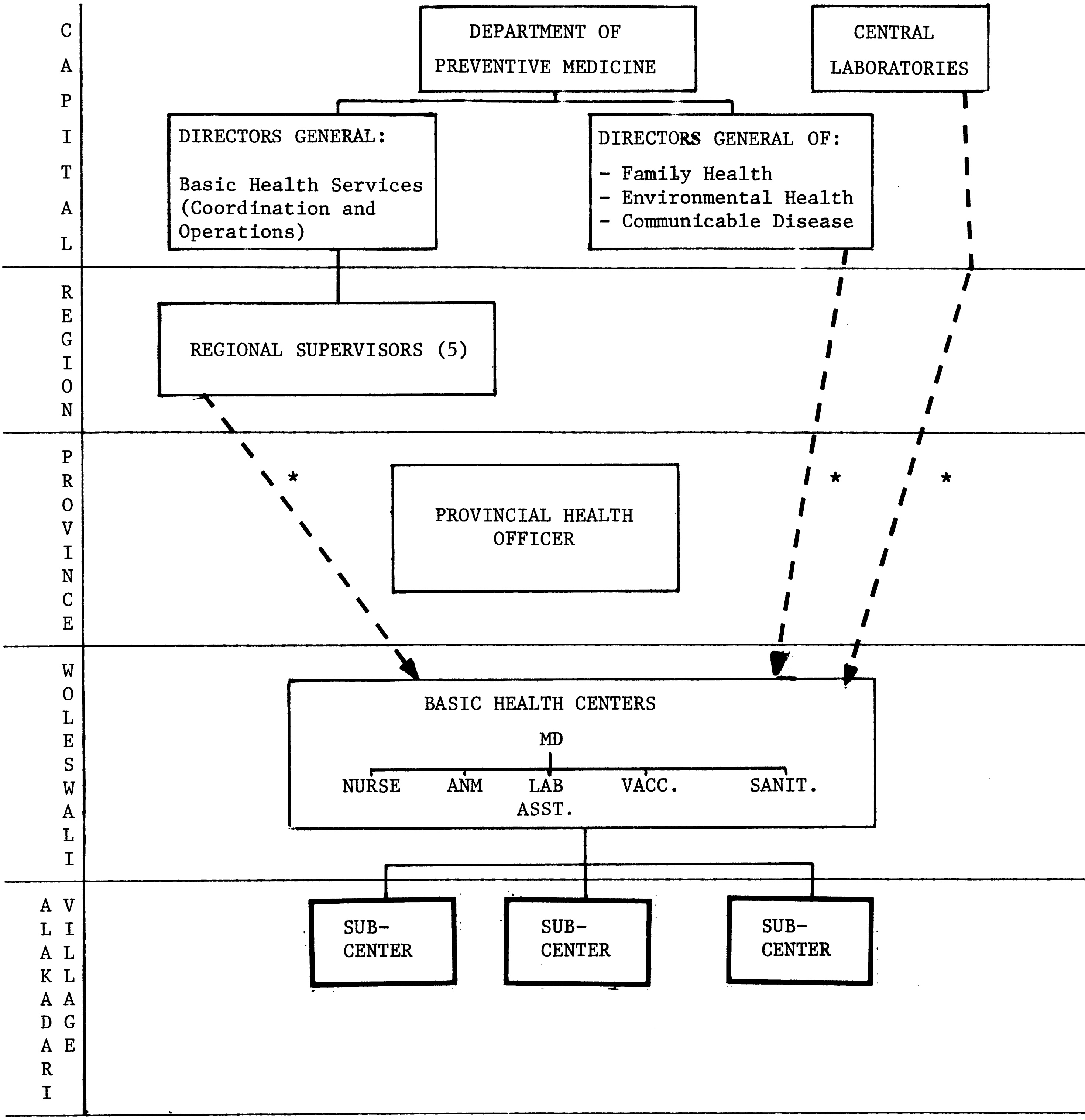
2.3.1 Objectives

As outlined in the current five-year plan, basic health centers should serve the following functions:

FIGURE 2.6

BASIC HEALTH SERVICES

ORGANIZATIONAL STRUCTURE



* Periodic Supervision

a) Maintenance of mass campaign programs: Malaria, Smallpox and TB;
b) Preventive medicine, including environmental health and communicable disease control;
c) Medical referral from basic health centers to supplement limited BHC curative service;
d) Establishment of family health services - family guidance and MCH.

2.3.2 Organization and Control

As noted in Figure 2.2, BHC are centrally monitored by the Director of the BH Services as a function of the Department of Preventive Medicine. Figure 2.6 outlines the present or proposed organizational relationships in the MOPH. In practice, supervision and support to date have been largely limited to sporadic field visits by Kabul staff; the Provincial Health Officer has little regular contact with, or sense of responsibility for, basic health services. See Sections 3.1 (Personnel) and 3.5 (Management Control and Supervision).

2.3.3 Staffing

A practical Health Center staffing pattern is still evolving (though in the five-year plan a large staff was considered), consisting of the following:

No.	Title
1	Doctor
1	Nurse-Midwife
1	Nurse (male)
1	Sanitarian
1	Clerk/Storekeeper
1	Vaccinator
1	Lab. Technician
2	Administrative Assistants
1	Storekeeper
1	Driver
	Plus contract employees
11+	

In practice, Centers generally have several vacancies, due in part to:

a) National shortages of various personnel categories, particularly female nurses and midwives;

b) Unclear task assignments and division of responsibilities, which compound the difficulty for the central personnel office in setting priorities in personnel assignments;

c) The posting and transfer process, presided over by a Transfer Committee, which at this point has little access to information as to present staffing and priorities.

These issues are further examined in Section 3.1 (Personnel) and 3.5 (Management Control and Supervision).

2.3.4 Location

Centers are usually located in the principal towns of the woleswali. An increasing number of centers are being provided with new government-

owned facilities, though many centers located in rented buildings seem generally adequate in terms of space and minimum hygiene.

2.3.5 Health Center Materials and Equipment

Most aspects of fitting out a center are based on standard patterns and lists of supplies (including both government and UNICEF supplied drugs), equipment, transport and budget. The present and proposed specifications are included as Appendix 1. While such standardization is useful as a tool for an efficient initial supply process, MOPH leaders are well aware of the need to develop more flexible supply procedures and reporting mechanisms for the longer term.

2.3.6 Characteristics of BHC Service Delivery - Centralized Clinic Orientation

The people must come to this clinic for virtually all BHC services, as no practical strategy for extension to the village level has yet been decided upon. A tentative plan attaching three to four satellite or sub-centers (perhaps staffed by a nurse and a vaccinator) to each Basic Health Center has been considered, but not systematically examined in relation to alternative approaches, such as working more directly with village health workers.

2.3.7 Characteristics of BHC Service Delivery - Curative Orientation

A review of the actual work currently done in a health center points out that the services are almost entirely curative, with a few immunizations, vitamins and food supplements provided as part of a

developing Family Health emphasis. The sanitarian, as principal resource for preventive health activities, appears to be the most chronically under-utilized person in the health center.

2.3.8 Family Health Activities

Family Health is intended to be a priority function of the Basic Health Services. In this regard, the MOPH has established a Family Health Bureau in the Department of Preventive Medicine, and is:

a) Training a cadre of auxiliary nurse midwives;
b) Receiving large amounts of drugs, supplies and equipment, largely donated by UNICEF, for the health center family health effort;
c) Receiving food supplements for mothers and young children, through the World Food Program;
d) Receiving contraceptive supplies, donated by USAID.

An on-site survey of approximately 40% of all operating health centers suggests that, at this writing, a substantial proportion of health centers see no more than 10-20 persons a day, mostly adult males. UNICEF supplies and equipment now stock virtually all operating health centers, and WFP food supplements are being distributed to most centers. Approximately 43 ANM's are now assigned to the field, with about 28 in health centers and 15 in provincial hospitals. Contraceptive supplies are currently neither stocked nor distributed through the health centers, although several qualified

authorities, the success of AFGA clinics in certain parts of the country, and reports from BHC staff, indicate that there is a demand for contraceptive services in a number of areas.

The present delivery strategy is for each clinic to have 2-3 weekly "family health days" concentrating on food supplies and family guidance. Some BHC doctors and others are of the opinion that the main motivation for coming to these centers is to receive the food supplies. This tendency is reinforced in the present setting, where little other care is provided, and attendance falls when food supplements are in short supply.

2.3.9 Analysis and Summary of Opportunities for Action to Improve Rural and Family Health Delivery

While a reasonable beginning has been made for Family Health, a number of needs and problems must be acted upon to get the Basic Health Center concept in motion. These include:

2.3.9.1 Training and Attitudes of the Doctors

The medical educational process (large urban hospital settings and curative focus) and the social reward system (high income and prestige from private practice) often result in BHC physician absenteeism and other evidence of low commitment to rural health needs. As they are neither taught nor rewarded for interest in rural and preventive medicine, there is little reason to expect commitment to it. The

practical implications of this world-wide problem are to:

a) Avoid reliance on the use of physicians where other personnel can be used;

b) Organize health activities to use the doctor's particular skills efficiently - that is, as managers and teachers of other personnel who can handle the majority of routine problems, and for the difficult, unusual, and less routine problems which cannot be taught to and divided among other personnel.

The development of health worker manuals containing simple problem/action protocols, and clear task assignments for all staff members, can be a major step. Related actions are summarized in Section 3.5 (Training), in the work plan, and in Appendix 5.

2.3.9.2 Job Descriptions and Division of Responsibilities

Comprehensive job descriptions exist as an approved part of the five-year plan. However, simplification to specific tasks, and clear MOPH specification of responsibility and authority of each BHC worker, backed up by on-the-job training, can help break the current inertia which results from workers not knowing clearly what they are to do. Most health center tasks are best done by non-physicians, and most programs need not be dependent on the immediate involvement or responsibility of the BHC physician.

2.3.9.3 Technical and Administrative Supervision

The Directorate of Basic Health Services is attempting to implement a regional supervision system. Since family health is the major

area of BHC activity envisioned, the Family Health Bureau is interested in developing a capacity for direct supervision by their own staff, although this does not seem to be a realistic possibility at this time. As it is clear that all of the delivery effort, and much of the training and problem solving, must take place at the clinic level, constructive supervision must be available if the family health program is to succeed. The proposed Basic Health Services supervisory sustem, using health center work programs and health worker manuals discussed below, may be part of the solution for these problems.

2.3.9.4 Basic Supporting Medicines and Equipment

Although perhaps available somewhere in the system at any given time, many health centers lack the appropriate blend of medicines and equipment needed for a viable family health program, such as prenatal vitamin/iron supplements, baby scales, and contraceptives. Clinics are frequently overstocked with low demand items (e.g., remedies for heart palpitations and indigestion) while being out of stock for months on high demand items such as vaccines, antibiotics, eye ointment, and aspirins. Similarly, some health centers have excess equipment, while others fall short.

2.3.9.5 Female Staff Members

The reluctance of rural women to deal with non-family males often tends to keep women from clinics, leaving the man to bring children

in. This in turn is often only for acute, curative problems that are relatively far advanced. When WFP food supplements are out of stock, women have even less motivation to come to clinics.

It is the team's opinion that present and potential MOPH initiatives for further training and use of female staff in rural health work, whether at the health center level or as a village worker in cooperation with health center activities, is perhaps the single most important step in bringing realistic and practical rural health services to the people.

2.3.9.6 Personnel Posting to Health Centers

The Health Center location of the first class of ANM's was unknown to appropriate MOPH officials for months after their graduation. Additionally, half of the 45 ANM's in the second class are from the Kabul area. These findings suggest, at minimum, the need for simple control of personnel record keeping, and improved personnel selection procedures to allow geographic placement at centers near their homes.

2.3.9.7 Rural Confidence in Modern Medicine and Reliance on Rural Remedies and Healers:

As practical people, rural Afghans may well remain reliant on local cures until they are convinced that something consistently better is available. There are no short term solutions; however, as practical steps, based on an assessment of what rural people perceive as their needs, a vigorous program to utilize available resources effectively can include:

a) Improvement of local healers and health practices through training and government policy support; improvement of the pharmacies through the new government policy on use of a limited formulary of generic drugs;

b) Continued development of the direct government supported health centers at the woleswali level, or the sub-centers at the alakadari level.

2.3.9.8 Health Education

Both staff and patients require educational support at the health center level. The staff, within the scope of their job description, need to know:

a) What problems they should attack, - how each worker's role relates to others in the center

b) What actions they should take, i.e., take history, give medicine or treatment, educate patient

c) What supplies are required

d) What information must be reported on their work

At the same time, patients are presently given little instruction in nutrition, hygiene, and family guidance, often because of poor work organization, limited staff knowledge, and lack of supporting supplies and equipment.

A promising area for action here is the development and widespread distribution of health worker manuals containing problem/action protocols, or step-by-step guidelines for recognition of, and appropriate action on, the major health problems facing health

workers at many levels. Problem/action protocols for each health worker can be developed from existing job descriptions and policies, and can be useful for in-service, on-the-job educational reinforcement as tools for practical supervisory assistance. With these specific technical guidelines, Health Center Workplans can be developed, specifying a schedule for the clinical, field, and administrative work required for staff members, together with the specific supply requirements.

2.4 SUMMARY OF POTENTIAL ACTIVITIES ADDRESSING THESE PROBLEM AREAS

Fortunately, many of the problems identified in Section 2.3 are amenable to practical attack and solution, given MOPH commitment to act decisively. Specific cooperative actions on the part of the MOPH, other assistance groups, and the Management Team, are outlined in Section 4 (Rationale for Strategy and Summary of Priorities), and Section 5 (Work Plan).

Figure 2.7 below suggests in overview how a small number of specific work areas relate to many rural health problems. These work areas include:

a) Training - Development and Use of problem/action protocols
b) Innovative Drug Use
c) Materials Management
d) Personnel Recruitment and Placement
e) Assessment of Rural Resources and Expenditures for Health

f) Finance and Budget

g) Statistics

h) Planning

Health center construction is not listed, in part to balance a general overemphasis on physical facilities. A major construction effort should not divert attention from the major health issues, which are rarely addressed adequately through buildings alone.

Section 3 will describe and analyze specific Management Operations and Planning Processes with the MOPH--the necessary administrative functions which together allow health services to be delivered.

3.0 MOPH ADMINISTRATIVE OPERATIONS

While overall government policy guidelines are important in setting plans for the health program of Afghanistan, of equal importance are the means by which plans get implemented. Senior MOPH officials have consistently communicated the belief to the Management Team that both planning and implementation must be improved together, a judgement on which the Team concurs as the only practical path for progress.

Section 3 outlines MOPH administrative processes which implement health activities in Afghanistan, and analyzes opportunities for improvements in:

3.1	Personnel
3.2	Materials Management and the MOPH Generic Drug Iniative
3.3	Finance and Budget
3.4	Training
3.5	Management Control - Statistical Data and Supervision
3.6	Planning

3.1 PERSONNEL

3.1.1 Overview

- 3.1.1.1 Number and Distribution of Personnel
- 3.1.1.2 Civil Service System

3.1.2 Organization and Processes

- 3.1.2.1 Central MOPH Organization
- 3.1.2.2 The Recruitment Process - Technical Personnel
- 3.1.2.3 Administrative/General Personnel Recruitment
- 3.1.2.4 The Assignment and Rotation Process
  - 3.1.2.4.1 Technical Personnel
  - 3.1.2.4.2 Administrative Personnel
  - 3.1.2.4.3 Information Flow
- 3.1.2.5 Evaluation and Promotion/Ranks and Seniority
- 3.1.2.6 Other Policies and Processes
- 3.1.2.7 Personnel Records
- 3.1.2.8 Field Organization
  - 3.1.2.8.1 Regional
  - 3.1.2.8.2 Provincial
  - 3.1.2.8.3 Basic Health Center
- 3.1.2.9 Personnel Utilization

3.1.3 Analysis

3.1.4 Selected Responses to Opportunities

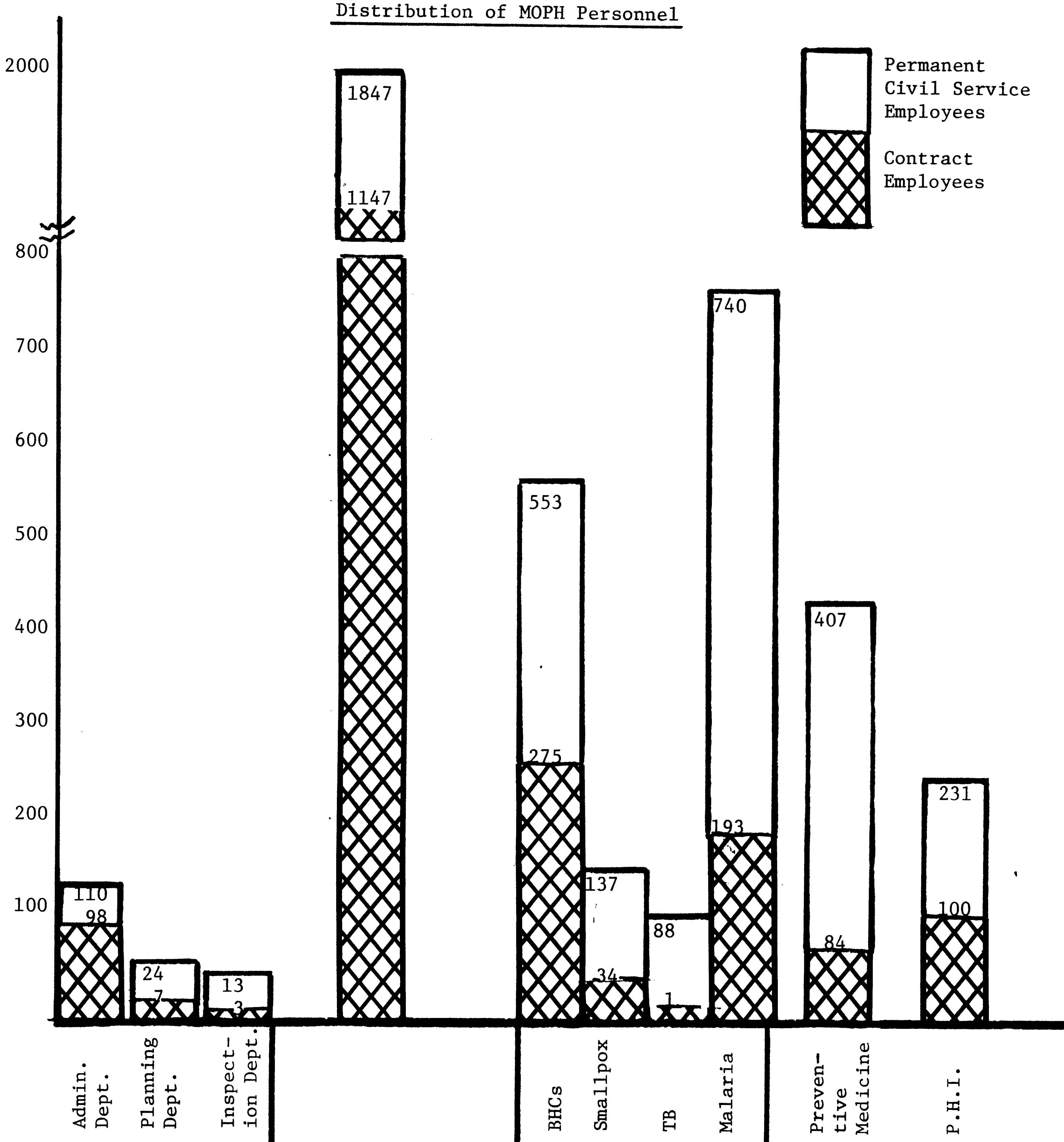
FIGURE 2.7

RELATIONSHIPS BETWEEN RURAL HEALTH DELIVERY PROBLEMS & AREAS FOR PRACTICAL ACTION BY MOPH, MANAGEMENT TEAM & OTHER ASSISTANCE GROUPS

HEALTH DELIVERY PROBLEMS	TRAINING PROBLEM ACTION PROTOCOLS	INNOVATIVE DRUG USE	MATERIALS MANAGEMENT	PERSONNEL RECRUITMENT & PLACEMENT	ASSESSMENT OF RURAL RESOURCES & EXPENDITURE	FINANCE & BUDGET	STATISTICS	PLANNING
A. Clear job descriptions, task divisions	X			X			X	X
B. Personnel posting to health centers	X			X		X	X	X
C. Basic supporting medicines & equipment	X	X	X		X	X	X	X
D. Technical & administrative supervision	X	X	X			X	X	X
E. Health Education	X	X						X
F. No female staff	X			X	X			X
G. Training & attitudes of doctors	X	X	X	X			X	X
H. Reliance on rural remedies		X			X			X

FIGURE 3.1.1

Distribution of MOPH Personnel



ADMINISTRATIVE	CURATIVE MEDICINE (incl. hospitals)	FIELD PROGRAMS	TECHNICAL SUPPORT
Total staff=225 4.1%	Total staff=2994 49.1%	Total staff=2021 33.2%	Total staff=822 13.7%

3.1 PERSONNEL

3.1.1 OVERVIEW

At present, tasks related to personnel management are in fact being carried out, but not in the most efficient ways. Since its personnel are without question the Ministry's most valuable resource, and since such great numbers of personnel are involved, even small inefficiencies in their management and utilization could be having adverse effects on the effectiveness of the Ministry's programs.

3.1.1.1 Numbers and Distribution of Personnel

The distribution of personnel at levels below that of the top leadership is shown in Figure 3.1.1. Although Figure 3.1.1 gives no indication of the proportion of administrative personnel within the operating programs, the gross balance between line and staff within the Ministry seems reasonable.

3.1.1.2 Civil Service System

The Ministry of Public Health, along with all other government organizations, carries out all procedures and organization concerning personnel in compliance with the national Civil Service Law. Some of the resulting elements of this system, which covers some 80,000 civil servants, are:

a) Excellent job security;

b) Difficulty in dismissing or punishing employees whose work is unsatisfactory;

c) Promotion to the maximum rank possible for the post held is dependent on reviews by superiors;

d) Seniority rules, which recognize a hierarchy of official ranks for filling vacant positions;

e) Inadequately detailed rules or guidelines for qualification and requirements for jobs;

f) Non-existent or inadequate job descriptions for either technical or administrative positions;

g) A personnel record system containing much useful information but in such an archaic form that access is very difficult.

In practice, the actual processes in use are somewhat more flexible than the Civil Service Law, resulting in:

a) The possibility of a high-rank position being filled temporarily by a lower-ranking civil servant who may be qualified to do the job;

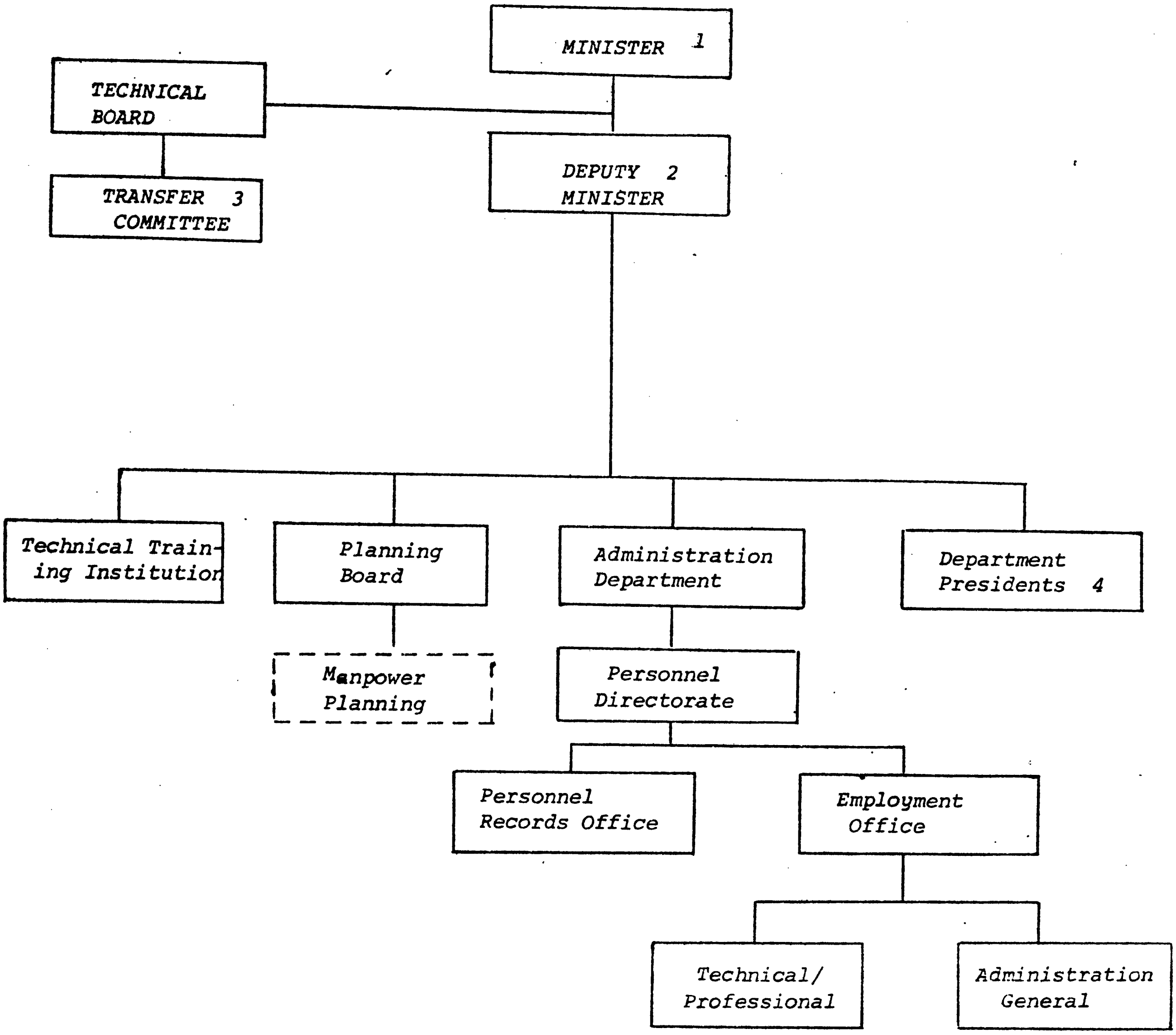
b) The possibility of a person having the right connections or personal influence being appointed to a job for which he may not be the most qualified applicant, or being transferred to a job in desirable location;

c) The possibility that the existence or availability of personnel qualified to fill a vacancy may not become known to the persons responsibile for filling it;

d) The possibility that the system of rewards and punishments for good and poor performance, already quite feeble, may often be further weakened, or otherwise misused.

Figure 3.1.2

Organization Units Concerned with Personnel Management



1. *Minister: Must approve appointments & promotions grade 8 to 6*

2. *Deputy Minister: frequently acts on personnel decisions on behalf of the Minister*

3. *Transfer Committee: Meets yearly around March 21 (technical personnel only)*

4. *Department Presidents: Approve promotion and appointments grade [illegible] to [illegible]*

3.1.2 PERSONNEL: DESCRIPTION OF ORGANIZATION & PROCESSES

3.1.2.1 Central Level of MOPH Organization

Figure 3.1.2 shows the organizational units concerned with personnel management.

3.1.2.2 The Recruitment Process - Technical Personnel

A distinction is made between technical or professional personnel (doctors, nurses, technicians, etc.) and administrative or general personnel (those without specialized health training).

Mutual obligations to hire and to serve result in virtually all Afghans who have been trained in some health specialty being employed by the GOA, usually either in the military or the MOPH. At present there are shortages of virtually all kinds of trained personnel.

Except for a few programs, no attempt is made to recruit from specific parts of the country, and the Personnel Offices do not coordinate recruiting with planning and training activities.

3.1.2.3 Administrative/General Personnel Recruitment

There are few general civil service openings and a large pool of eligible people. Vacancies are usually filled from pools in the following order:

a) Suitably qualified MOPH personnel who have been displaced from their jobs.

b) Qualified personnel from the MOPH or another Ministry (if transfer is approved at ministerial level).

c) Personnel displaced from other ministries.

d) The unemployed.

There is no civil service list of eligibles, nor does the MOPH maintain an application file. No public announcement of openings is made, to avoid being swamped with candidates; word-of-mouth procedures are relied on. Selection of university graduates (who enter at rank 9), is done by the Ministry of Planning. Selection of 12th grade graduates is largely on the basis of informal interpersonal communication, and they enter at Rank 10. Selection criteria are partly dictated by law, partly by the MOPH and include: educational level, work experience, character references and a physical examination.

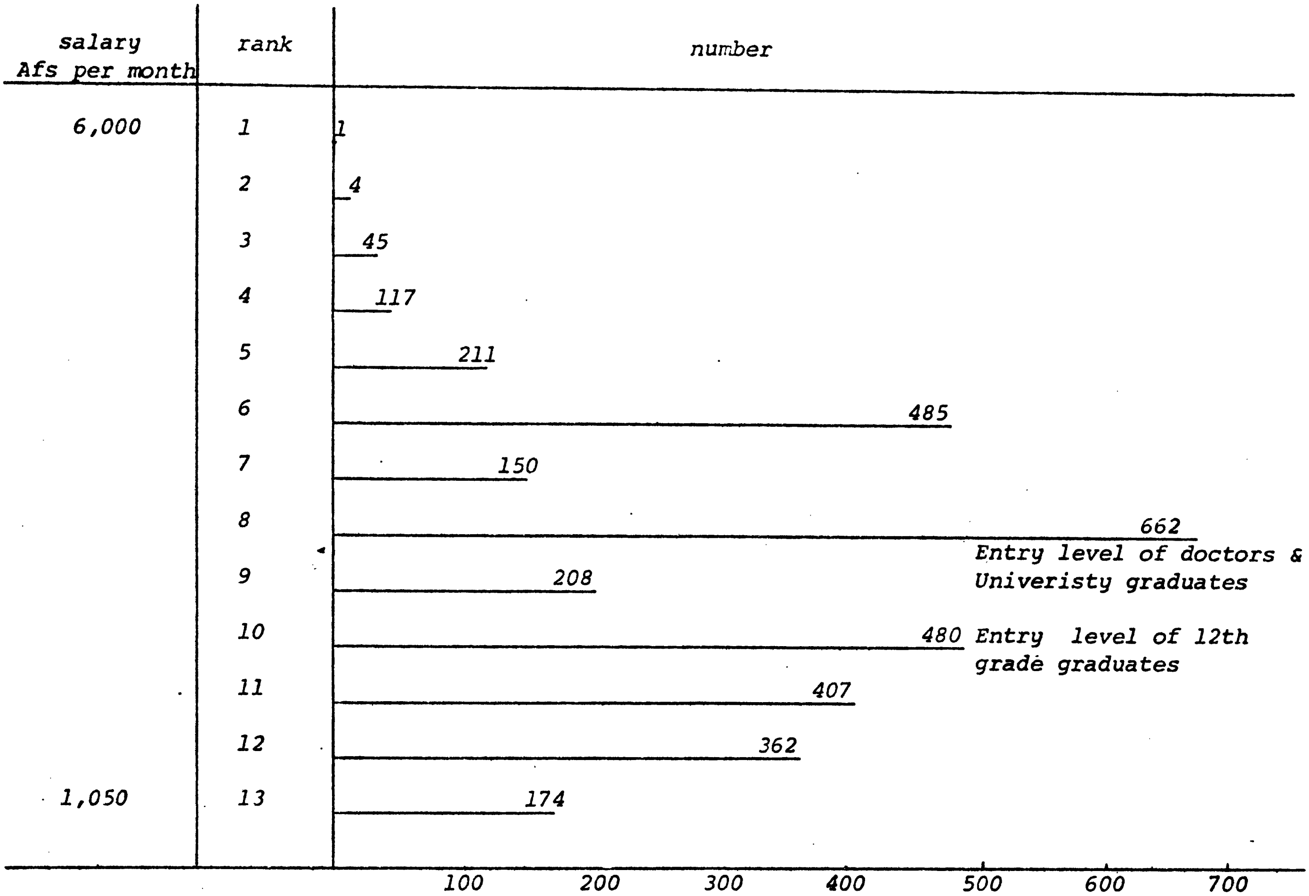
3.1.2.4 The Assignment and Rotation Process

3.1.2.4.1 Technical Personnel

Among new technical personnel only doctors are allowed to defer military service; all others enter a lottery to determine when they serve. Doctor assignments are determined by a uniform ("concours") examination, with highest-scoring candidates being assigned to desirable posts under experienced doctors in larger hospitals and urban centers, and lowest scoring candidates assigned to basic health centers. Health center doctors may elect a one-year public health course or go straight to a health center.

Figure 3.1.3.

The Present Distribution of official Ranks in the MOPH



The MOPH has a widespread policy of rotating technical personnel every two years, to spread the benefits and burdens of desirable and undesirable areas. These decisions, of paramount importance to those affected, are made by a committee selected annually from the Technical Board and Administration Department. Since the amenities of living and, in the case of doctors, personal financial condition hinges on job location, it is widely known that the annual transfer process is an occasion for exerting influence and meting out punishment.

3.1.2.4.2 Administrative Personnel

Initial placement is of major importance since this class of personnel is not rotated regularly. Where there are several qualified candidates for multiple positions, the general criteria of "suitability" is used. Level of entry rank is determined by law, based on education and work experience, and transfers can be made only by request or approval of the Minister.

3.1.2.4.3 Information flow to program control centers is so slow or non-existent that managers frequently have quite unlimited ideas of staffing levels and patterns.

3.1.2.5 Evaluation and Promotion

The present distribution of official ranks in the MOPH is shown in Figure 3.1.3 (Malaria Program excluded). Starting salaries are low, and the incremental steps are miniscule as well as infrequent.

Employees are eligible for promotion every two to four years. Ratings in eight categories of performance and behavior are given by two of the civil servant's superiors. An average rating of 3 (out of 5) is required to be eligible for a step salary increase, and average of 4 for a promotion in rank. All promotions and increases must be approved by a higher authority, the Council of Ministers, or the President in the case of the higher ranks. Promotions may be withheld temporarily for budgeting reasons. Poor job performance or infraction of regulations may result in warnings from the supervisor, and then notification of the higher line of authorities. Transfer is the usual form of punishment, and two transfers are possible before mandatory discharge.

3.1.2.6 Other Policies and Processes

Redundant personnel must be placed in new positions or the Ministry must continue to pay their salary for one year if they remain unemployed. The civil servant may be required to fill a job carrying lower rank than his normal job, but retains the higher rank salary. An employee may be moved into a higher position on a temporary basis and receive the salary for the position but not the official rank.

3.1.2.7 Personnel Records

Upon entering the civil service, a number of official forms are prepared and kept in a file-binder by the Personnel Records Office. These folders follow a civil servant if he is transferred to

another Ministry. At the MOPH they are filed according to professional category and date of hire. No other records are kept. The following information can be found in each "background file":

a) Confidential Background Form
b) Health Form
c) Signed Loyalty Oath
d) Official letters of assignment
e) All "enforcement" forms, by means of which all appointments and subsequent changes in status are officially made.
f) Personal Property Registration Form
g) Background Record Form

3.1.2.8 Field Organization

The central and field personnel organization structure of the MOPH is shown in Figure 3.1.4.

a) Regional Level - With the exception of the Malaria and Small-pox Programs, there is as yet no substantial personnel function performed through the regional supervisory structure.
b) Provincial Level - The PHO has only a limited role in the management of the BHC personnel, getting involved only in cases of transfer for reasons of flagrant misconduct. He has no responsibility for smallpox or malaria personnel, but is responsible for rating the performance of the BHC doctors, made presumably on the basis of infrequent visits to health

centers. The PHO himself has no formal job description which sets his responsibility towards the BHC's in his province.

c) BHC Level - The doctor has principal personnel responsibility, and theoretically prepares and/or signs the monthly records of staff attendance used for salary disbursements, along with the woleswal. The personnel review function is often viewed by both the doctor and his subordinates as a punishment/control device. Although job descriptions exist in the Five-Year Plan for Basic Health Services, there are no job descriptions in actual use within the BHCs to serve as personnel review guidelines.

3.1.2.9. Personnel Utilization

Figure 3.1.5 shows how field personnel of the three major field programs of the MOPH are utilized to deliver the services on which the MOPH has placed high priority. BHC field visits indicate several consistent patterns of staff utilization problems:

a) General curative treatment is the BHC doctor's main activity. Since screening of patients is rarely done, the doctor sees everyone who comes to the clinic. The time he can spend on serious cases would be thus severely limited if the facility becomes widely used.

b) The activities of the ANM at present are usually limited to distributing WFP supplies. She rarely makes good use of her training.

Figure 3.1.4

MOPH FIELD PROGRAMS ORGANIZATION STRUCTURE

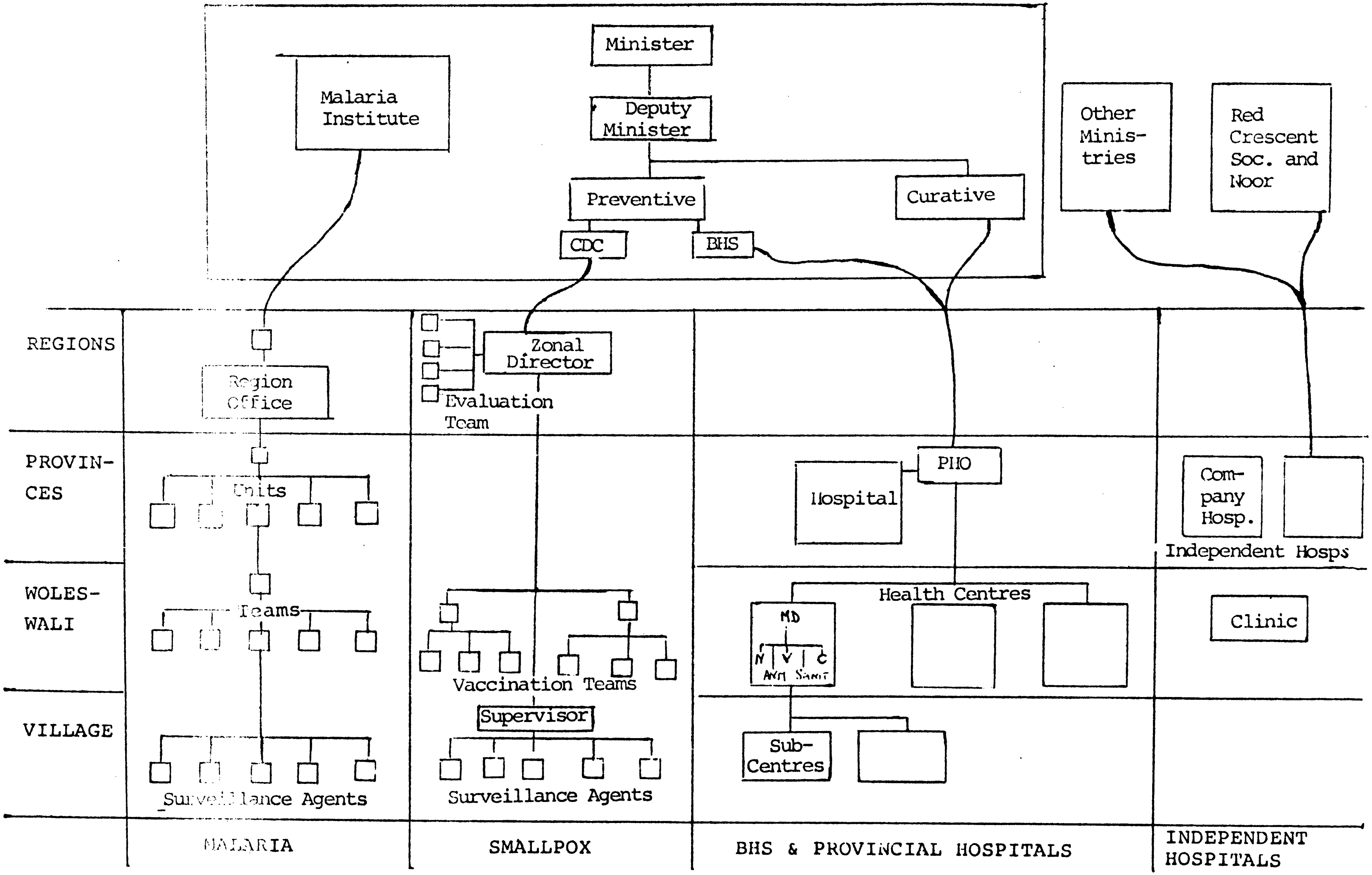


FIGURE 3.1.5

PERSONNEL RESOURCES AVAILABLE TO MEET HEALTH PROBLEMS

MAJOR HEALTH PRIORITIES IN AFGHANISTAN AS EXPRESSED BY MOPH

		MAJOR MOPH FIELD OPERATIONS PRESENTLY IN OPERATION		
		BASIC HEALTH SERVICES	MALARIA ERADICATION	SMALLPOX ERADICATION
Diarrhea	Referral	Doc.	Surv. Agent, Super-visor	(6)
Diarrhea	Case Detection & Treatment	(3) Doc., Vacc.	Surv. Agent, Super-visor, (5)	Surv. team, Vacc. team, Assess ment teams
Diarrhea	Vaccination	Vacc.		Vacc. team, Surv. team
Tuberculosis	Referral	Doc.		Sanit., Super-visor
Tuberculosis	Vaccination	Vacc., Nurse		Vacc. team, Surv. Agent, Assess ment teams (8)
Tuberculosis	Case Detection	Doc., Lab Asst.		Sanit., Super-visor
Tuberculosis	Curative	Doc., Nurse		
Smallpox	Referral	Doc.	Surv. Agent, Super-	(6), Surv. team, Eval. team, Vacc. team
Smallpox	Case Detection	(3) Doc., Vacc.	Surv. Agent, Super-visor, (5)	Surv. team, Eval. team, Vacc. team
Smallpox	Vaccination	Vacc.		Vacc. team, Eval. team, Surv. team
Malaria	Gambusia		Gam-busio-logist (4)	
Malaria	Spraying		Surv. Agent, Super-visor, Hired labor, Kabul team	
Malaria	P.C.D.	Doc., Lab Asst.		
Malaria	A.C.D.		Surv. Agent, Super-visor, Micro-scop-ist	
Curative & Preventive Progs.	Health Statistics	Doc., All HC Team	Unit Off'cr, Super-visor, Surv. Agent, Micro-scopist	Zonal Direc., Sanit., Super-visor
Curative & Preventive Progs.	Health Education	(2) Sanit, ANM		
Curative & Preventive Progs.	Environ-Health	Sanit		
Curative & Preventive Progs.	Family Health	Doc. (1) ANM, Lab Asst.		
Curative & Preventive Progs.	Curative Treatment	Doc., Nurse	Super-visor, Surv. Agent	
		Greatest Responsibility → Supportive	Greatest Responsibility → Supportive	Greatest Responsibility → Supportive
		DIVISION OF RESPONSIBILITIES WITHIN FIELD PROGRAMS		

NOTES TO FIGURE 3.1.5

1. In most health centers the doctor is in charge of what family health services exist, and this mainly is the distribution of World Food Program supplies (wheat, milk, and oil). However, where an ANM is posted to the health centers, she is most commonly in charge of the MCH program.

2. The sanitarian's tasks are varied, and in theory at least, are in the area of health education. In practice however, this activity has never been observed or properly described.

3. This is entirely passive case detection (PCD).

4. It is not known who the supportive personnel in this activity are, or could be. The post of gambusiologist is yet to be filled. (Gambusia is a fish which eats mosquito larvae.)

5. The Malaria Program, along with other field units, have been requested to refer any suspected smallpox and diarrhea cases to the responsible officers, and this cooperative referral appears to be effective.

6. There is no single staff member responsible for detecting and referring these communicable diseases. Often the first warning signs are given by the people themselves.

7. The smallpox program has had a history of cooperation with the Department of Communicable Diseases in preventing the spread of cholera, whenever cases are spotted.

8. In December, 1973, a pilot project in Kunduz province was begun with the Smallpox Teams doing mass BCG vaccination along with their usual smalpox vaccination.

c) The sanitarian is the least utilized member of the BHC staff. Although his duties include environmental health and health education, he rarely is able to carry them out. Unsupported by the doctor, he lacks transport and has never been seen to have the tools and supplies needed for the upkeep of wells and pumps, and has no educational aids.

d) The vaccinator, for some of the same reasons as the sanitarian, is also fairly inactive and his range of field work is usually limited to a small radius from the BHC.

e) The compounder is an anachronism since he merely hands out prepared pills. (Note: As of the new Afghan year (1353) there will be no compounders in Basic Health Centers. All will be posted to pharmacies.)

3.1.3 PERSONNEL: ANALYSIS

A review of the existing organization and procedures in MOPH personnel management brings several important sources of inefficiency to light.

3.1.3.1 Because of the way in which new administrative personnel are recruited, the MOPH has no assurance that the most highly qualified, reliable, and motivated personnel possible are entering its ranks.

3.1.3.2 Although technical personnel are currently in short supply, there is neither any guarantee that the Ministry's needs will ever be met, nor that oversupplies and imbalances will be prevented due to the lack of coordination between the personnel, planning and training functions of the MOPH.

3.1.3.3 Incentives for good performance are sorely lacking. Blame for this falls largely on the civil service system and an economic environment which makes it possible for a doctor to vastly increase his personal income at the expense of his official performance.

3.1.3.4 Without making any value judgements, sub-optimal utilization of personal resources is but one clear danger of the intervention of personal influence in the transfer process. That this practice should exist is hardly surprising, given the scale and importance

of family and social ties, and the lack of either a rational transfer system or an effective means of rewarding performance.

3.1.3.5 Financial difficulties in cutting back redundant or obsolete personnel makes it almost impossible to upgrade the MOPH staff during times of budgetary stricture.

3.1.3.6 Lack of easily accessible personnel record information compounds the problems of program administration and personnel management. The present record system is a bottleneck which either delays decisions about staffing, transfers, training, etc., or prevents any rational decision from being made. Program managers rarely have up-to-date manpower information on hand.

3.1.3.7 Shortages of trained personnel managers and supervisors exist at all levels.

3.1.4 PERSONNEL: SELECTED RESPONSES TO OPPORTUNITIES March 74

In an area of management loaded with cultural values and legal strictures, the selection of problem areas for inclusion in this initial work plan is necessarily limited.

3.1.4.1 A personnel index system, to which program managers will have ready access, will be developed. This will include such characteristics as education, training, work experience, geographic origin and preference, language ability, etc., in cross-referenced form for ease of access by MOPH decision makers.

3.1.4.2 Formal training in personnel management will be conducted subject to the availability of suitable candidates.

3.1.4.3 Attempts will be made to assist recruitment practice in terms of geographical distribution of candidates for training, and placement of personnel in locations where they speak the language, know the culture and are acceptable to the population.

3.2 MATERIALS MANAGEMENT

3.2.1 Overview

3.2.1.1 Introduction

3.2.1.2 People, Materials, Systems

3.2.1.3 Existing Conditions

3.2.1.4 Generic Drugs

3.2.2 Description of Organization and Processes

3.2.2.1 Central Level

3.2.2.1.1 Requisitioning
3.2.2.1.2 Warehousing
3.2.2.1.3 Purchasing
3.2.2.1.4 Issuing and Property Accounting
3.2.2.1.5 Transport
3.2.2.1.6 Emergency Procurement

3.2.2.2 Centrally Based Programs and Major Hospitals

3.2.2.2.1 General Procedure
3.2.2.2.2 Smallpox Program

3.2.2.3 Provincial Level

3.2.2.3.1 Purchasing

3.2.2.4 BHC's

3.2.2.4.1 Central Supply Provision
3.2.2.4.2 Storage
3.2.2.4.3 Local Procurement

3.2.2.5 Pharmaceutical Materials

3.2.2.5.1 Drug Procurement
3.2.2.5.2 Drug Distribution

3.2.3 Analysis

3.2.3.1 Central Warehouse

3.2.3.2 Information Flows

3.2 MATERIALS MANAGEMENT

3.2.1 OVERVIEW

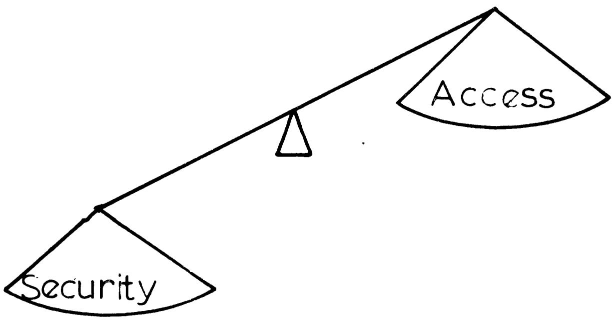
3.2.1.1 Introduction

This section will discuss the way the MOPH performs the basic "life-support" functions of purchasing, distributing, and accounting for the physical materials needed to carry on all its activities.

That the MOPH does indeed function is proof that some minimal materials management system does exist. But there are indications that this area may become a serious bottleneck unless some improvements are made before the MOPH steps up the overall level of its programs. Fortunately, the MOPH has recognized these problems and has taken important actions to rectify them.

3.2.1.2 People, Materials, and Systems

In any organization or system in which people come in contact with property belonging to someone else, there is always a trade-off between the benefits accruing from security for and access to the property.



In the extreme, the two are mutually exclusive. Perfect security is no access. Perfect access is no security (No guards, locks, paper controls, or 3-man committees). The important characteristics of the two extremes are:

	High Security Low Access	Low Security High Access
Relative Financial Loss (from theft)	LOW	HIGH
Relative Efficiency Loss (from paperwork & locks)	HIGH	LOW

3.2.1.3 Existing Conditions

Materials management in the MOPH (and most other GOA institutions) leans toward the high security, low access extreme. Losses due to theft are low, but inefficiency is high, resulting in services not getting delivered in a timely manner.

The nature of these inefficiencies will be detailed below. While the result of delays and inefficiency on service delivery cannot be measured precisely, suffice to say that the financial losses alone from carefully locked up materials being rendered useless are many times those resulting from deliberate theft.

3.2.1.4 Generic Drugs

In terms of health care provided per unit cost, the use of drugs by the entire health system of Afghanistan (including the GOA, MOPH, and the private individual) is operating substantially below its potential efficiency. The MOPH has determined significant improvements would result if medicines were procured and used under their generic names instead of brand names. (See Parts 2.4 & 3.1 of this Section & Appendix 3.)

FIGURE 3.2.3

PRESENT REQUISITION ——> ISSUE PROCESS AT CENTRAL LEVEL

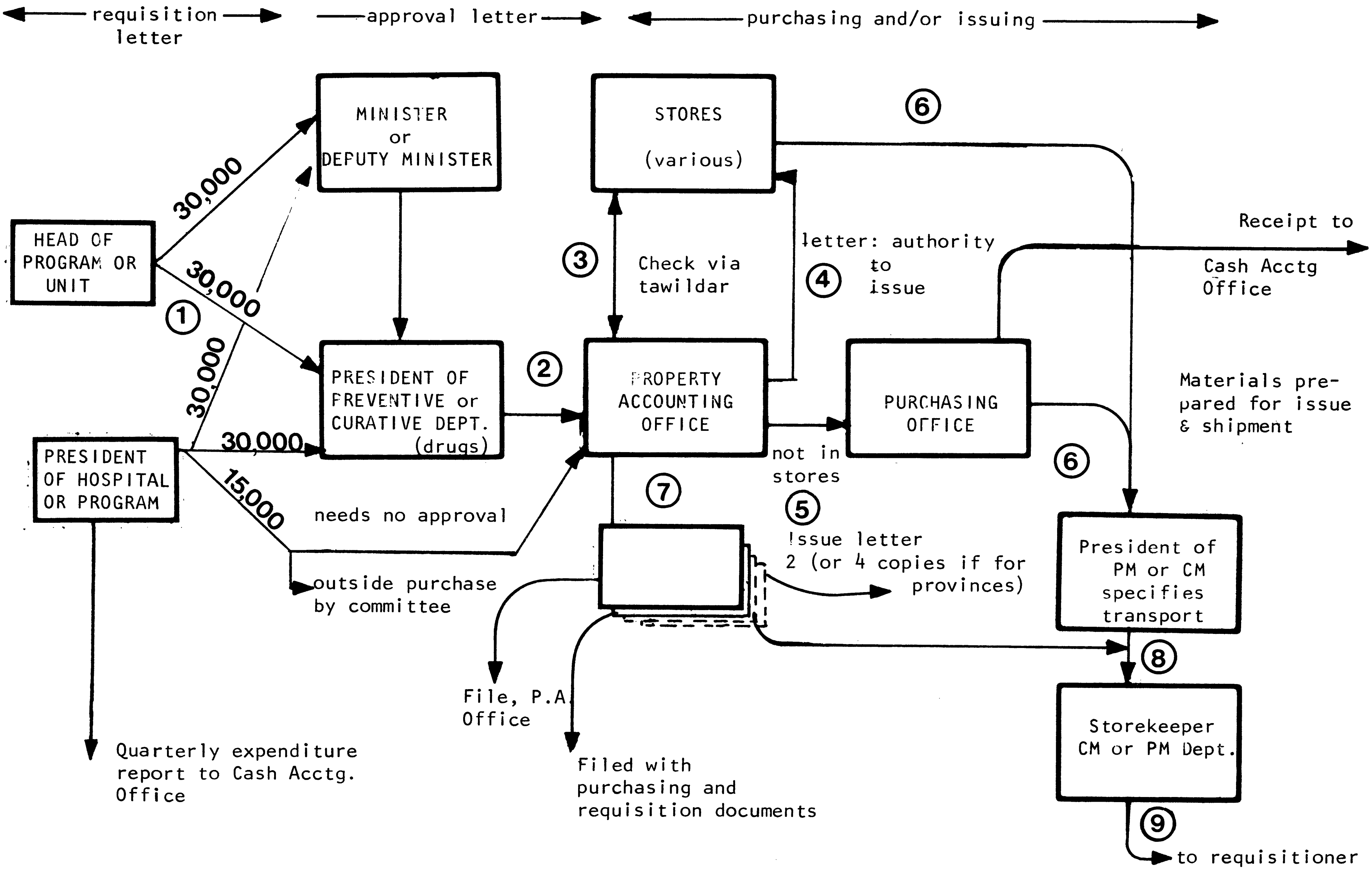
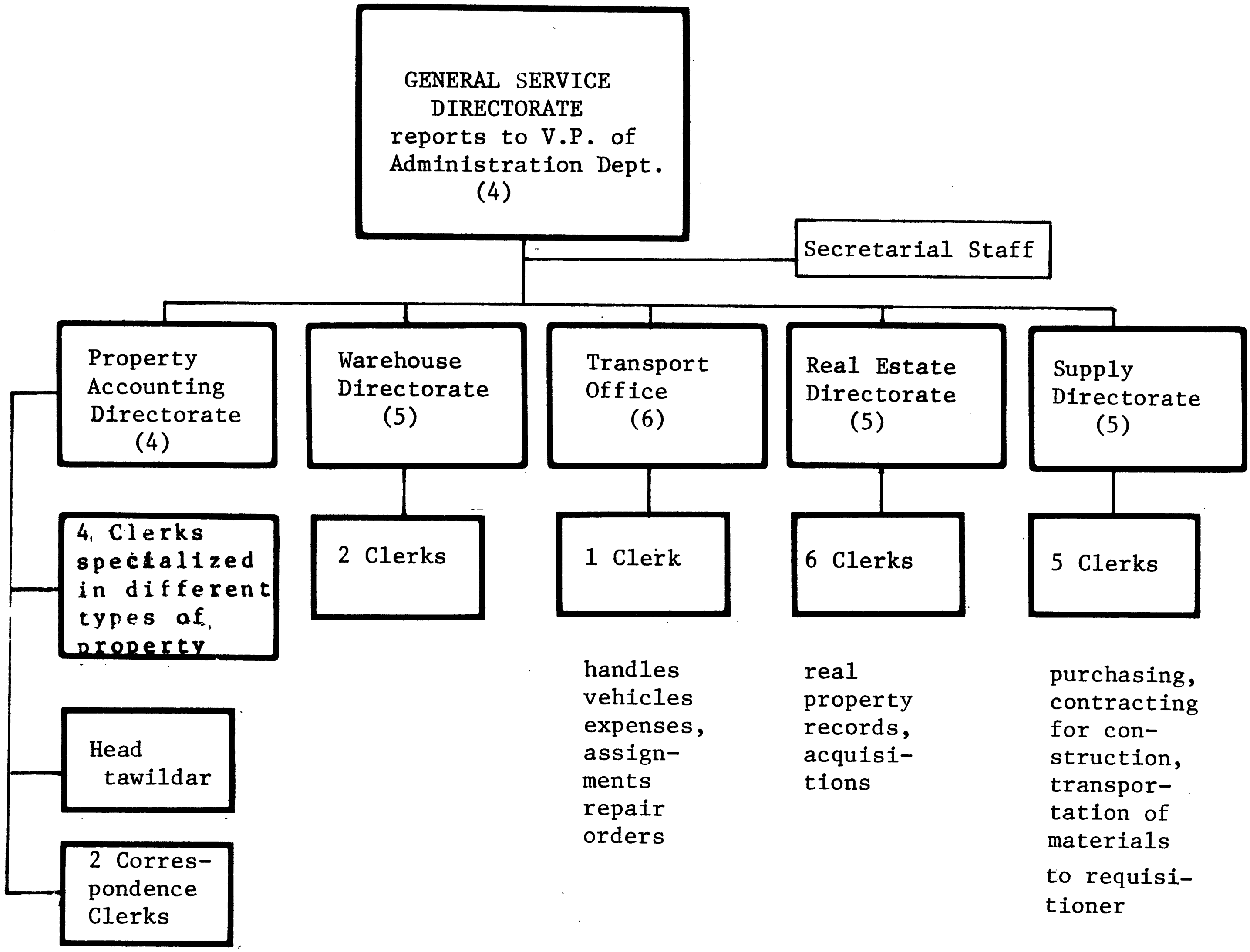


FIGURE 3.2.2.

PRESENT KREDAMAT STRUCTURE



3.2.2 DESCRIPTION OF ORGANIZATION AND PROCESS

3.2.2.1 Central Level

Logistical support for the MOPH is centered in a branch of the Administration Department known as the Khedamat (General Services) as noted in Figure 3.2.2.

3.2.2.1.1 Requisitioning Materials - Figure 3.2.3.

Most operating supplies are issued on a regular, annual basis to field health delivery units. Heads of departments, programs, and major hospitals submit their requirements to the Administration Department. The Presidents of Preventive and Curative Medicine must approve these annual requisitions.

Extraordinary requests during the year are transmitted by official letter, and are handled in various ways:

a) If a value of less than 15,000 Afs. (30,000 for Kabul hospitals) is involved, the hospital or program head usually has the authority to send the requisition directly to the Khedamat.

b) If between 15,000 and 30,000 Afs. is involved, the President of the line department must first approve it, and send back an official letter.

c) For over 30,000 Afs., the Deputy or Minister must approve the requisition.

3.2.2.1.2 Warehousing

Upon receiving an approved requisition letter, the Property Accounting Office directs the head storekeeper to check if the requested material is available from the MOPH's warehouses. None of these warehouses at present is particularly well suited for the job of properly storing drugs, food, or medical equipment, with the marginal exception of temporarily leased hangars at Kabul Customs. The typical warehouse is a dark, decrepit room kept locked and sealed by a storekeeper who has assumed personal liability for the material entrusted to him in return for his salary. This arrangement has several shortcomings:

a) Since the storekeeper is never on the premises, he must first be located and sent to search his storeroom. If he is sick or on leave or otherwise indisposed, no material can be taken from the warehouse. Long delays are not uncommon.

b) The storekeepers have very little experience or familiarity with the proper identification, storage, or handling of medical and technical supplies. With the exception of the stores for UNICEF/WFP commodities at Customs and the BHC drug storeroom, the Ministry's present stores are poorly kept and badly organized.

c) Since separate storerooms are kept for different classes of supplies, e.g., drugs, stationery, furniture, construction materials, etc., the time to fill any request for more than one type gets multiplied accordingly.

d) Each storekeeper has his own inventory list for which he is

responsible. These individual lists constitute the MOPH supply inventory.

e) Due to general disorganization of its warehouses, the MOPH incurs substantial losses due to spoilage of medicines and food, damaged equipment, and materials which simply cannot be found.

3.2.2.1.3 Purchasing

If a requisitioned item cannot be found in the storehouses, it must be purchased (provided money exists in the appropriate budget). For materials which can be purchased in Afghanistan, the Khedamat Supply Office conforms to MOF regulations in its purchasing procedures:

a) If the cash value involved is less than 20,000 Afs., a 3-man committee procures the item locally.

b) If more than 20,000 Afs. is to be spent the MOPH must announce its intention to purchase by radio and receive bids.

c) For all major purchases the Minister must give the Supply Office written approval before finally placing an order.

d) When the material is received it is entered on the inventory list of the appropriate storekeeper.

For items that must be ordered from abroad, including most materials ordered from development budget projects, the Coordination Department takes over the procurement process. After the goods are

cleared through customs by a Khedamat representative they pass officially into the possession of the MOPH via the inventory list of the head storekeeper.

3.2.2.1.4 Issuing and Property Accounting

After the materials are received and entered on a storekeeper's inventory, an official letter from the head of the hospital, program, etc., to transfer them to their own stores is submitted. The Property Accounting Office then prepares a form authorizing the transfer from the Ministry's stores.

a) When the materials are to remain in the central area, one copy is filed in the Property Accounting Office and another copy attached to the procurement documents file in the Supply Office.

b) If the materials are to be sent to the provinces, two additional copies are prepared. One is sent via official channels to the destination to inform the user of its impending arrival,and the second accompanies the material.

c) This system of property accounting exists in the same form down to the lowest level. When the material finally arrives at the location of the ultimate user, it is locked up in the care of a storekeeper. If it is to be issued to one person another official letter is issued by the local authority and kept on file with the storekeeper's inventory.

3.2.2.1.5 Transport

a) The MOPH itself owns very few vehicles suitable for deliveries

to the provinces. Materials are often sent by private truck, the parcel post service, or by domestic airline.

b) The official who ultimately authorized the requisition also specifies the means of transportation. If the shipment is large, a 3-man committee from the requisitioning department in Kabul sends it and assumes responsibility for its safe delivery.

c) The copy of the issuing document sent via official channels serves as a packing list and allows the shipment to be checked upon arrival at the provincial site.

3.2.2.1.6 Emergency Procurement

In an emergency situation, the unit in need of supplies informs the appropriate President, who sends a request directly to the Supply Office.

a) With only this degree of authorization the Supply Office can make the purchase from a perpetual 50,000 Afs. petty cash account.

b) The material goes on the head storekeeper's inventory as per usual but can be sent directly to where it is needed. The resultant packing list or waybill removes the material from the storekeeper's responsibility.

3.2.2.2 Centrally-Based Programs and Major Hospitals

3.2.2.2.1 General Procedure

Hospitals and programs headed by an official of rank 1 or 2 can bypass the Khedamat for purchases under 15,000 Afs. A 3-man committee is formed in conformance with government regulations to do the bidding or shopping. The Khedamat then has no record of the purchase, but the material goes on the inventory of the storekeeper for the program or hospital until it is issued. The program or hospital sends expenditure reports to the Cash Accounting Office.

3.2.2.2.2 Smallpox Program

The Smallpox Program is atypical of MOPH programs in many respects, including the way it handles its supplies. The concentration of resources, from both MOPH and outside sources, probably cannot be replicated in other programs, but Smallpox verifies that good efficiency can be attained with streamlined procedures, good communications with field units, a modicum of planning, and appropriate supervision.

Administration of all aspects of the program is separate from other programs, and is carried out through regional (zonal) units. The level of central organization of the Program is such that activities of field units are planned and monitored at all times. Coupled with a good communication system, this enables the material requirements of the field units to be transmitted to regional headquarters in a timely manner so that the units can be supplied in order to carry out their planned activities.

Foreign donor agencies provide virtually all supplies and equipment. Vaccine is kept at P.H.I. and other supplies in the Program's own storerooms. Supplies are delivered to field units from the three zonal units or from Kabul, by the Program's own vehicles.

3.2.2.3 Provincial Level

3.2.2.3.1 Purchasing

The head of a health center or hospital has no authority to purchase supplies. He must either send a request to Kabul, or to either the local Mostafiat or the PHO. (The procedure apparently varies from province to province since some PHO's have authority up to several thousand Afs., while others must ask the Mostafiat for the smallest items.)

The Mostafiat records purchases along with its monthly expenditure reports to the MOF. The PHO also informs the MOPH via quarterly reports.

3.2.2.4 BHCS

3.2.2.4.1 Central Supply Provision

All supplies are sent directly from Kabul to the BHC's. The PHO plays no role in this process. Formerly the doctor or another staff member would come to Kabul to requisition the material, and then either send it back by bus or truck, or personally accompany it to the BHC. The BHC Director is now taking the initiative to procure

each Center's annual supplies and send them by the Ministry's own trucks.

Although an attempt is usually made to assemble and deliver UNICEF and GMD-provided supplies to the BHC together, it is not always possible because of different schedules of availability from the sources. Since there is no functional inventory system, each center receives its full standard allocation without regard to the stocks on hand.

3.2.2.4.2 Storage

The responsibility for all drugs and equipment in a health center usually falls on the nurse or the compounder. Since this amounts to financial liability, the system of locked cabinets is relied on for security. The usual problem then arises--non-availability of supplies when the designated storekeeper is not present.

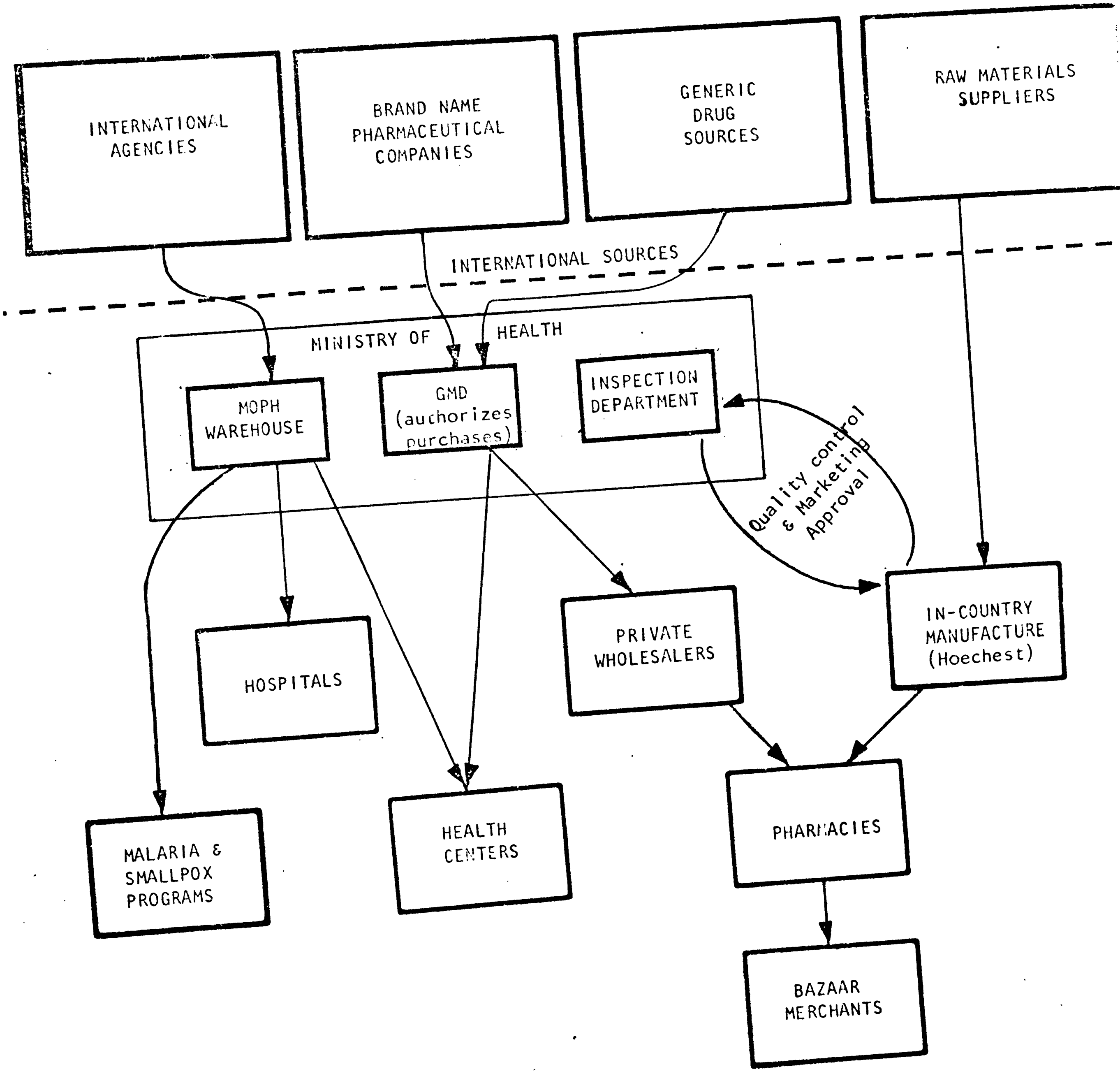
3.2.2.4.3 Local Procurement

Each health center has a small amount budgeted each quarter for the purchase of a few necessary operating items such as stove wood, kerosene (for sterilizing and for the refrigerator), and minor office supplies like ledgers and stationery. The procedure works as follows.

First, the health center initiates a requisition form listing the required items. This is sent to the local Woleswali Finance Office (WFO). Next, the WFO reviews this for conformance to the existing quarterly fund allocation for the center. If correct, it

FIGURE 3.2.4

DRUG PROCUREMENT & DISTRIBUTION



is approved by the Woleswal. Then, a 3-man committee is formed to do the actual purchasing. This is composed of one representative each from the Woleswal's office, the WFO, and the health center. The health center representative is usually the storekeeper. The money for the purchase is turned over to the committee prior to the purchase. Some WFO's are casual enough about these minor purchases to ignore the practice of forming a committee, but that is somewhat exceptional.

3.2.2.5 The Role of Pharmaceutical Materials in Afghanistan

Drugs are a critical part of the material inputs for a national health program, and the process of drug regulation in terms of procurement, distribution and use is an extremely important area of MOPH responsibility and opportunity. Figure 3.2.4 sketches the Procurement and Distribution Process.

3.2.2.5.1 Drug Procurement

Drug procurement from international sources by approximately 30 distributors is under MOPH regulation. Raw materials are converted into finished goods by the General Medical Depot (GMD) to meet some government needs, and by a private manufacturer, Hoechst Afghanistan, with a present monthly sales volume which would extrapolate to 140,000,000 Afs. per year, primarily for the private market. Most drugs are imported as brand name pharmaceuticals in finished, packaged form.

3.2.2.5.2 Drug Distribution

A network of 500 to 600 private and government operated pharmacies, as well as government hospitals and health centers make drugs available to the people. Access to drugs without physician's prescription is widespread, with two important effects:

a) Pharmacists and other health workers can play an important direct role in identifying problems and providing treatment;

b) Bazaar merchants and shopkeepers supplement the pharmacy system by stocking small supplies of medicines in villages and areas not having access to a doctor, pharmacy or health center.

3.2.3 ANALYSIS

Performance of the material management functions in the MOPH is presently limited by deficiencies in facilities, systems (procedures), organization, and personnel.

3.2.3.1 Central Warehouse

The MOPH has recognized that the lack of a modern central warehouse is responsible for some of the problems it encounters in running its programs. A new building was started two years ago and will be completed early in 1353. Current plans are for the contents of most of the existing storehouses to be consolidated into the central warehouse.

3.2.3.2 Information Flows

The dominant characteristic of the present system is that a large amount of information enters it and is processed, but remains largely unused for management purposes. Thus, faulty decisions resulting in sub-optimal use of resources are commonplace, while time and manpower are spent either generating more unused or useless information or trying to distill what is really useful out of poorly organized information.

3.2.3.3 Organization

The materials management organization is too decentralized for effective functioning in some areas, and too centralized in other respects. Adherance to certain archaic institutions of personal

responsibility for property and for decision-making result in inefficiencies which will persist regardless of other changes.

3.2.3.4 Management Decision-Making

Attention has to be paid to the development of a true management decision-making capability, so that the information which will have been made available in useful form can in fact be used.

3.2.3.5 Rural Health Services

A rational system of determining the material needs of BHC's, procuring them efficiently, and distributing them in a timely manner is required so that services can be delivered.

3.2.3.6 MOPH Generic Drug Initiative

In October, 1973, the Minister requested that the Management Team assist the MOPH in analysis of the procurement, distribution, and use of drugs in Afghanistan, expressing concern about this issue because of two points: the difficulty in getting appropriate, good quality drugs available to the people throughout the country at reasonable, inexpensive prices; and the major loss of foreign exchange to the nation, estimated to be 5 million dollars per year, which is roughly equivalent to the entire MOPH Ordinary and Development Budgets, largely for expensive foreign brand-name drugs. In brief, the most important issues and findings include:

3.2.3.6.1 Foreign Exchange

Major savings are possible through: limitation of the number of different drugs purchased to the single most useful drug in each class; consolidated national bid purchasing, to generate economies of scale in order size; and consideration of in-country production of common, high volume items.

It is important to note that, as approximately 90% of the drug imports are destined for the private pharmacies, little or no foreign exchange saving is likely without consolidated procurement. At the same time, it must be recognized that the major in-country producer, Hoechst Afghanistan, presently operates under contracts with the government under provision of the Private Investment Law. Should the government decide to proceed with the generic drug initiative, it would seem to be beneficial for the country to seriously consider cooperation with Hoechst Afghanistan in view of their experience and high quality in-country industrial plant.

3.2.3.6.2 Possibility of Revenue Generation for the MOPH

Many public health programs fail because they "cost too much", and cannot support themselves, and this will certainly happen in Afghanistan in a period of expanding health programs and severely constrained and perhaps fixed budget. The MOPH Generic Drug Initiative provides the only foreseeable opportunity to seriously consider generating income to support or expand MOPH programs.

Two major possibilities are:

a) through income generated from fees gained by brokerage participation in central coordinated purchasing of the country's medicines;

b) through a system of charges for medicines supplied through the government health services. Alternative strategies to look at possible ways to help the MOPH program pay for itself can be explored, and perhaps at the same time provide increased incentives for health workers to work in rural areas.

3.2.3.6.3 Appropriate Drugs

While some modifications may be useful, the recently produced Afghan Generic Drug list is a reasonably inclusive statement of the drugs appropriate for the health problems faced in Afghanistan. Revisions should be considered prior to any serious planning for implementation.

3.2.3.6.4 Availability of Drugs

The pharmacy network of about 600 outlets, together with the bazaar merchants and others who sell drugs, represent a major, underutilized group of health workers already active in every community of any size. The MOPH, by exercising simple regulatory authority, may well be able to improve the availability and quality of health care through simplification of drugs sold generically, and by providing the pharmacies with manuals to assist in recognition and appropriate treatment of simple problems.

3.2.3.6.5 Appropriate Drug Use

Drugs are widely available now. It is impractical, and in the Management Team's judgement undesirable, to attempt to restrict drug use through physician prescriptions. Practical steps which may realistically lead to more appropriate drug use include the shortened generic formulary discussed above, the development of simple problem-action and treatment manuals for all health workers and pharmacies as noted above, and uniform, clearly labelled packaging of drugs. This packaging would provide in the majority of cases sufficient medicine for treating the problem correctly (For example, tablets to treat pneumonia or an attack of malaria in one package, or family planning pills packaged for a month's use). The packaging would feature clear instructions, in Farsi, and Pashto, on the package itself, perhaps with a color-coding for each package corresponding to the official government prices for the medicine, these having been publicly posted and broadcast to minimize overcharge.

3.2.3.6.6 Summary opinion

The generic drug initiative is an extremely important opportunity for Afghanistan. However, it is a complex issue, and while successful achievement is possible should the government decide to proceed, it cannot happen overnight. The groundwork and organization must be carefully built to insure that the final result is improved health for the people.

3.2.4 SELECTED RESPONSES TO OPPORTUNITIES

3.2.4.1 The Warehouse Project

The Ministry has not only recognized that materials management is a serious weakness, but has already committed substantial resources to improving its capability. The establishment of the new warehouse and a new information system to go with it was the first task given to the Management Team.

3.2.4.1.1 The Central Warehouse as the Nucleus of a Logistics System

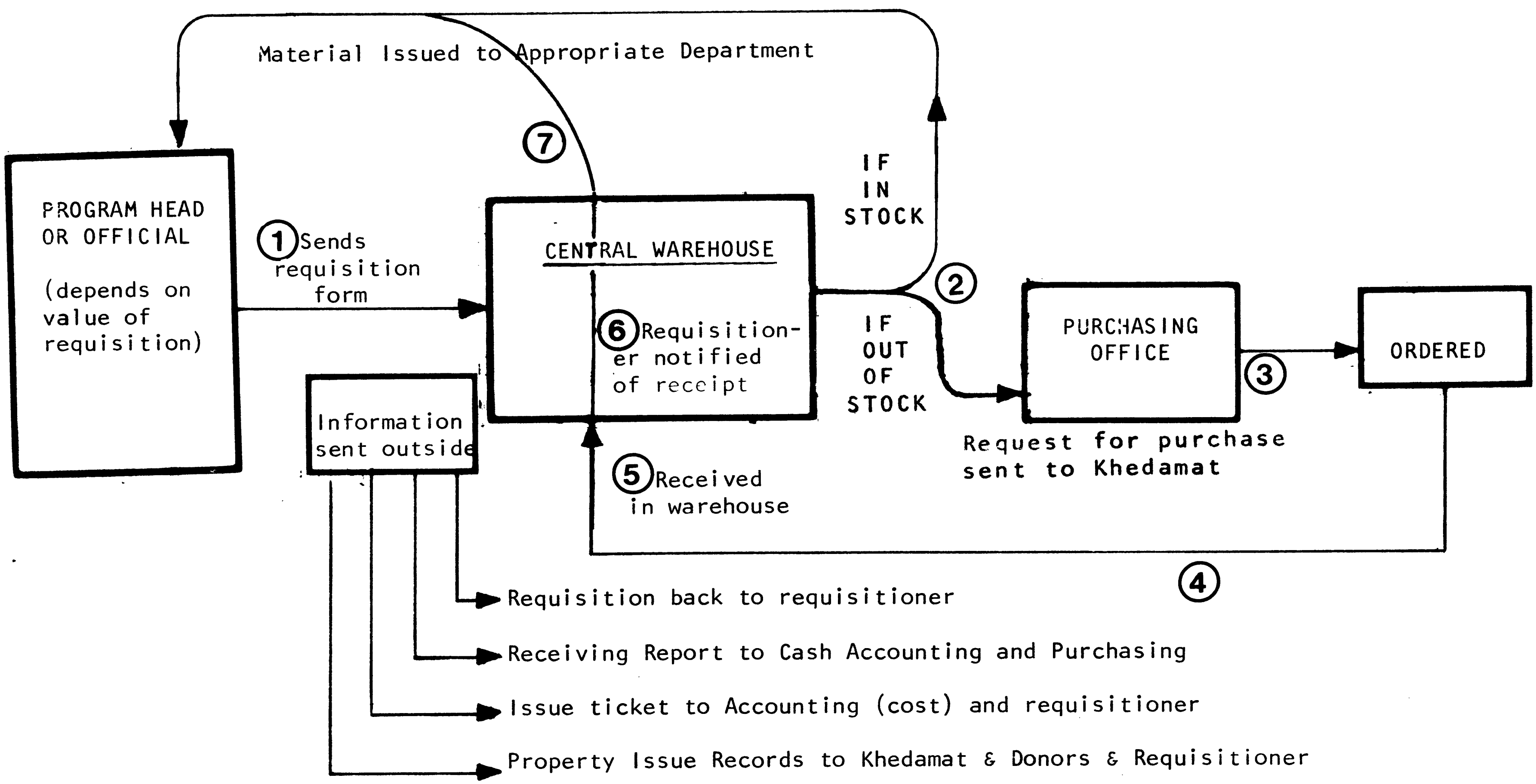
Fortunately, it appears that the new warehouse can serve as a nucleus for the development of an efficient logistics/materials management system in the MOPH. Plans for work in this area in the coming months all rely on this strategy. We feel that the opportunities for action are numerous enough to offer many angles of attack on the broad problems of institutions, organization, personnel, and information.

3.2.4.1.2 The Team's Activities

To achieve the goal of starting the warehouse in operation by the start of 1353, one Management Analyst will be working in an advisory capacity to the Afghan Warehouse Manager and Deputy Manager. A new information system has already been designed and accepted, and job descriptions have been prepared for the staff. Work remaining falls into the basic categories of:

FIGURE 3.2.5

PROPOSED REQUISITION ⟶ ISSUE/INFORMATION SYSTEM



a) Training the managers in the operation of the information system and in modern warehousing practices, and training the new staff in the skills needed to perform their jobs;

b) Advising on the layout and arrangement of physical facilities so that operations can be carried on efficiently;

c) Observing closely the initial phases of operations, as materials are transferred from present warehouses and the new information system is primed;

d) Training administrators within the Ministry's line departments to interface with the new system.

3.2.4.1.3 Expected Results

The obvious effects of this stage of work will be a step towards centralization of facilities for the Ministry by consolidating some six to eight storehouses, and an improvement in the physical storage and access of its supplies (See Figure 3.2.5). The new information system will be initially operating only within the warehouse, which for management purposes will become a self-contained functional block, a source of rapid access to information about stock levels and prices. Logistically, it will become a point to which a properly approved requisition document is taken and from which the needed materials are quickly issued.

The new system will also provide a streamlined procedure for obtaining the needed authorizations, based on Ministry of Finance

regulations. The internal inventory system will also provide the necessary information to the Supply Department so that inventories can be maintained at optimal levels. A new property accounting system will have been established within the warehouse to eventually supplant the present one. The system will also feed up-to-date information to donor agencies.

3.2.4.1.4 Effects on Efficiency

This should result in substantial gain in efficiency over the present system, where delays, errors and spoilage are normal. With the new warehouse established, any office requiring materials can telephone the central warehouse, to see if the desired material is in stock, learn its value for the purpose of seeking the proper authorization and budget control clearance, and then send an approved requisition to the warehouse for immediate issue.

Within the warehouse itself, no tawildar has the solitary key to the right door. This hopefully will be the beginning of a transition from a system of personal financial liability for the care of Ministry property to one in which a group is entrusted with the safe-keeping of property, in which periodic audits, paper controls, and sanctions take the place of radically restricted physical access. It is hoped that the trade-off between security and flexibility will not be an unprofitable one.

In addition to information on inventory levels, the new system will generate data on rates of material usage, costs of materials

requisitioned by the various programs, and the field locations of non-expendible property. The additional information will probably not be used at first but can be stored separately and become the basis for subsequent phases of management system development.

3.2.4.1.5 Effects on Organization

One organizational result of the establishment of the warehouse will be the effective elimination of one or two of the major functions of the present Khedamat. Although the central warehouse will come under the direction of the Khedamat, the very establishment of a large, physically separated, modernized operating unit will certainly set the stage for further changes.

All key documents will be special forms (already approved by the Ministry of Finance) rather than lengthy official memoranda. A relatively small staff will be able to process a high volume of orders. Procedures will be clear and logical, with job descriptions tailored to fit the procedures.

3.2.4.1.6 Expanding the Logistics System

The central warehouse established, attention can be focussed on related parts of the logistics system. One candidate for immediate attention is the Property Accounting Office of the Khedamat, which will be automatically receiving copies of property record cards prepared when non-expendibles are issued from the warehouse. Here

the major task will be to put existing records into the same form and organize it to yield useful information. At the other end of the system, a simple yearly property inventory procedure will be established for all field operating units.

3.2.4.1.7 Other MOPH Warehouses

The next step will be to establish copies of the central warehouse system in all other remaining warehouses. This will permit development of a central system of data collection and analysis, as well as improving the quality of information available to management at the program or hospital level.

3.2.4.1.8 Cost Accounting

Another obvious development would be the capacity to convert data on material usage into a form useful to top management. The establishment of a cost accounting section in the Administration Department should proceed quickly following the acceptance of a "cost center" concept of financial management.

3.2.4.1.9 Transport

The Central Warehouse is an ideal location for a strengthened transportation section and could become the hub of a logically-designed distribution system. The volume of goods transported will naturally be limited by the resources (vehicles,personnel) made available, but the proximity to the future Transport and Equipment Maintenance Organization (TEMO) will become a valuable asset.

FIGURE 3.2.6

AFGHANISTAN - INNOVATIVE DRUG USE PROJECT
STATUS REPORT TO MOPH MARCH 1974

(1) ISSUES OF GOVERNMENT CONCERN	(2) ACTIONS REQUIRED BY MOPH & MANAGEMENT TEAM	(3) STATUS OF ACTIONS TAKEN	(4) FINDINGS	(5) NEXT STEP
Loss of foreign exchange	→	→	Major Savings Possible by: 1. Limitation to major single effective drug of each type 2. Centralized national bid purchasing 3. Possibly by in-country production	
Procurement & Production	Contact potential suppliers, including UNICEF	Several firms interested. UNICEF HQ & Kabul open to MOPH request	All potential suppliers require estimates of present national consumption	1. GMD records of private sector purchases must be tabulated 2. Consultant ready to make on site survey and presentation to MOPH on production & interim foreign procurement 3. Revise drug & equipment list for UNICEF supplies to basic health services
Appropriate Drugs	1. Summary analysis of Afghan health problems → 2. Generic Drugs formulary → 3. Analysis of present drug consumption →	Completed Draft Completed GMD Purchases complete → private purchases not complete →	Only 5% (or $250,000) perhaps 95% of National Drug use →	Private purchase records at GND must be tabulated
Drugs available at reasonable prices	1. Study what people spend for medicines now 2. Study drug costs 3. Consider pricing strategies	→	→	1. Consider survey of what people actually spend now 2,3: Action awaits completion of drug list and quantities which will allow cost and pricing estimates
Drugs used correctly and effectively	1. Adapt MOPH guidelines to practical problem/action protocols for each health worker and pharmacy 2. Consider "course of treatment" packaging to dispense right amount of drugs	Draft in process with MOPH, WHO, UNICEF and Management Team Cooperation →	→ →	1. Consider field test in selected Basic Health Centers 2. Consider field test with Basic Health Center Drugs
Good Quality Drugs		Consultation from International Agencies and Private Firms	Recommend International standard quality control	Await action on specific government procurement plan

3.2.4.1.10 Property Transfer and Disposal

The Materials Management System developed and approved by the Ministry of Finance also includes procedures for dealing with the transfer and disposal of property. These will be implemented by integrating them into the work of the appropriate departments.

3.2.4.1.11 Staffing and Training

Video tapes of the first warehouse training sessions are being made for use in training subsequent cohorts for the remaining warehouses. For the rest of the development projects, one-to-one training will be used on the pattern followed with the warehouse supervisory staff. Job descriptions will be prepared for all personnel concerned with materials management within the Administration Department.

3.2.4.2 The BHC System

Working within the Basic Health Services administration, the Management Team will help develop and implement an inventory control and reporting system operating from the health center level. This would allow the restocking of only needed items.

a) By rewriting job descriptions and the Health Center work plan, control and disbursement of medicines from the storerooms can be improved.

b) A possible solution to the problem of inadequate equipping of staff members could be wrought through a policy decision to as-

sign a basic kit of equipment personally to each staff member when he or she is posted to a health center. The kit would be turned in at the end of a BHC tour or taken to the next a.sign-ment.

c) Decisions and implementation at the Khedamat level will be required so that BHC's can be restocked more frequently, with GMD and UNICEF supplies coordinated.

d) By the time the TEMO facility is operational, there should exist a system for equipment and vehicle maintenance for all provincial health services which will facilitate timely transportation and repair of inoperative equipment.

e) A control system must be instituted in the Purchasing Office to ensure that funds earmarked for BHC development cannot be spent on other programs.

3.2.4.3. The MOPH Generic Drug Initiative

In view of the importance of the MOPH request, and the potential opportunity to improve the availability of rural and family health services, the Team is working intensively with the MOPH to analyze the drug situation. The issue is complex and Figure 3.2.6 is included to summarize the issues of government concern, the actions indicated to meet these concerns, the major findings to date, and the next steps required. Appendix 3 includes a more detailed statement of the Actions and Analysis to this point, and complete technical documentation is in process.

3.3 BUDGET AND FINANCE

3.3.1 Overview

3.3.2 Description of Organization and Process

3.3.2.1 Types of Budget

3.3.2.2 Financial Planning

1. Five Year Plans
2. Annual Ordinary Budget
3. Annual Development Budget

3.3.2.3 Acquisition of Funds

3.3.2.4 Transfer of funds

3.3.2.5 Financial Controls

3.3.2.6 Other Health Programs

3.3.3 Analysis

3.3.3.1 Financial Planning

3.3.3.2 Acquiring Funds

3.3.3.3 Transfer of Funds

3.3.3.4 Financial Control

3.3.3.5 Financially Attractive Program Alternatives

3.3.4 Responses to Selected Opportunities

3.3.4.1 Budget Formulation

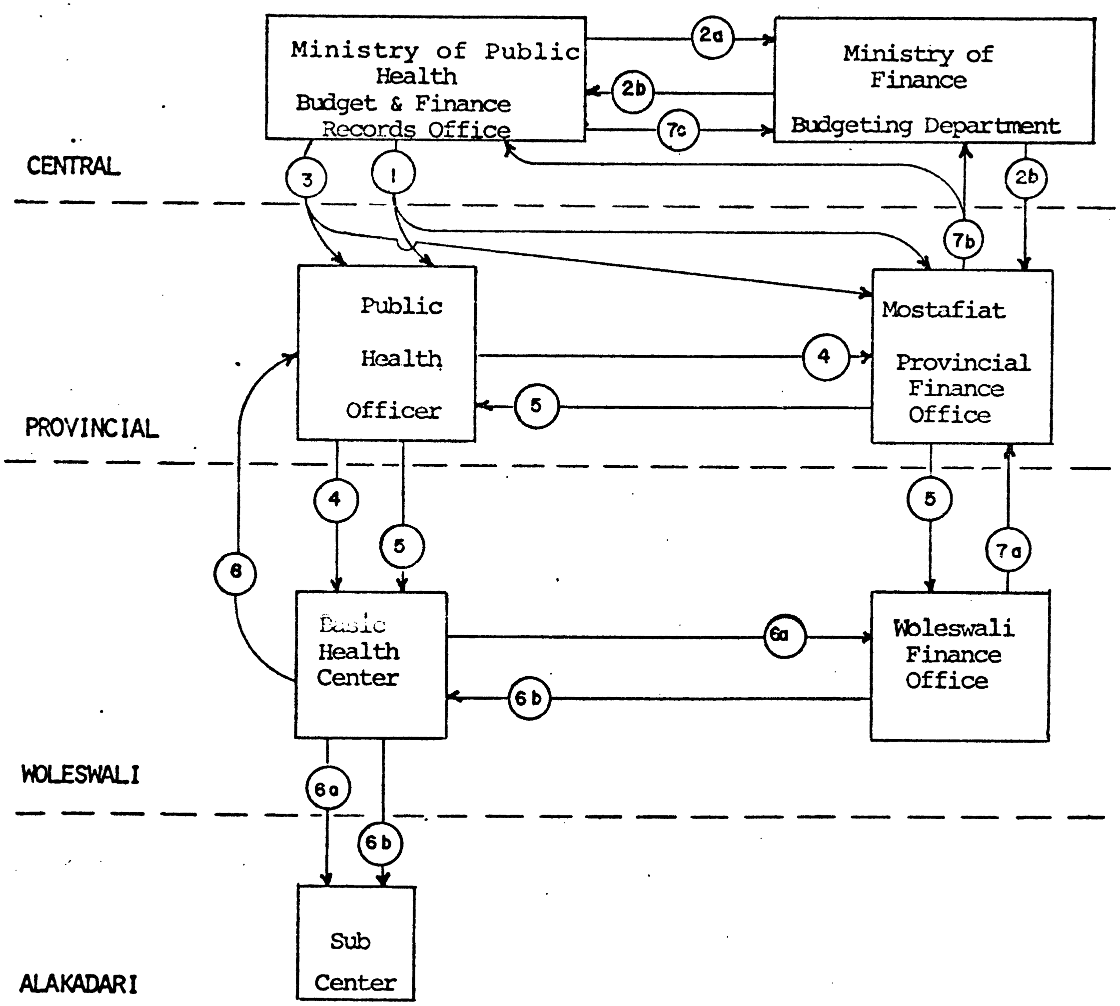
3.3.4.2 Financial Flows

3.3.4.3 Financial Reporting

Figure 3.3.1

FINANCIAL TRANSFER PROCESS

BASIC HEALTH SERVICES ORDINARY BUDGET



1. Annually, the MOPH informs each PHO and Mostafiat of their total provincial health operating budget, determined by MOF and the Council of Ministers.

2a. Quarterly, the MOPH requests funds allocation by MOF.

2b. Quarterly, MOF informs MOPH and Mostafiat of actual allocation.

3. Quarterly, MOPH informs PHO's and Mostafiats of breakdown of their Provincial allocations by major category (salaries, transport, rent, stationery, fuel, heating and miscellaneous).

4. Quarterly, at present, PHO sub-allocates the Provincial budget in each category to specific health facilities, informing them and the Mostafiat. (note: the MOPH now plans to have the central Admin. Dept. perform this function.)

5. Quarterly, the Provincial Mostafiat informs each Woleswali Finance Office of the detailed suballocations, preparing them for actual disbursement.

6a. Monthly, local health facilities request cash, using 6 copies of each of two forms.

6b. Monthly, cash is disbursed to health staff directly. The Health Center staff attendance record, signed by the BHC doctor and countersigned by the Woleswali, is required documentation prior to release of salary funds.

7a. Monthly, the WFO aggregates disbursement records and forwards to PFO.

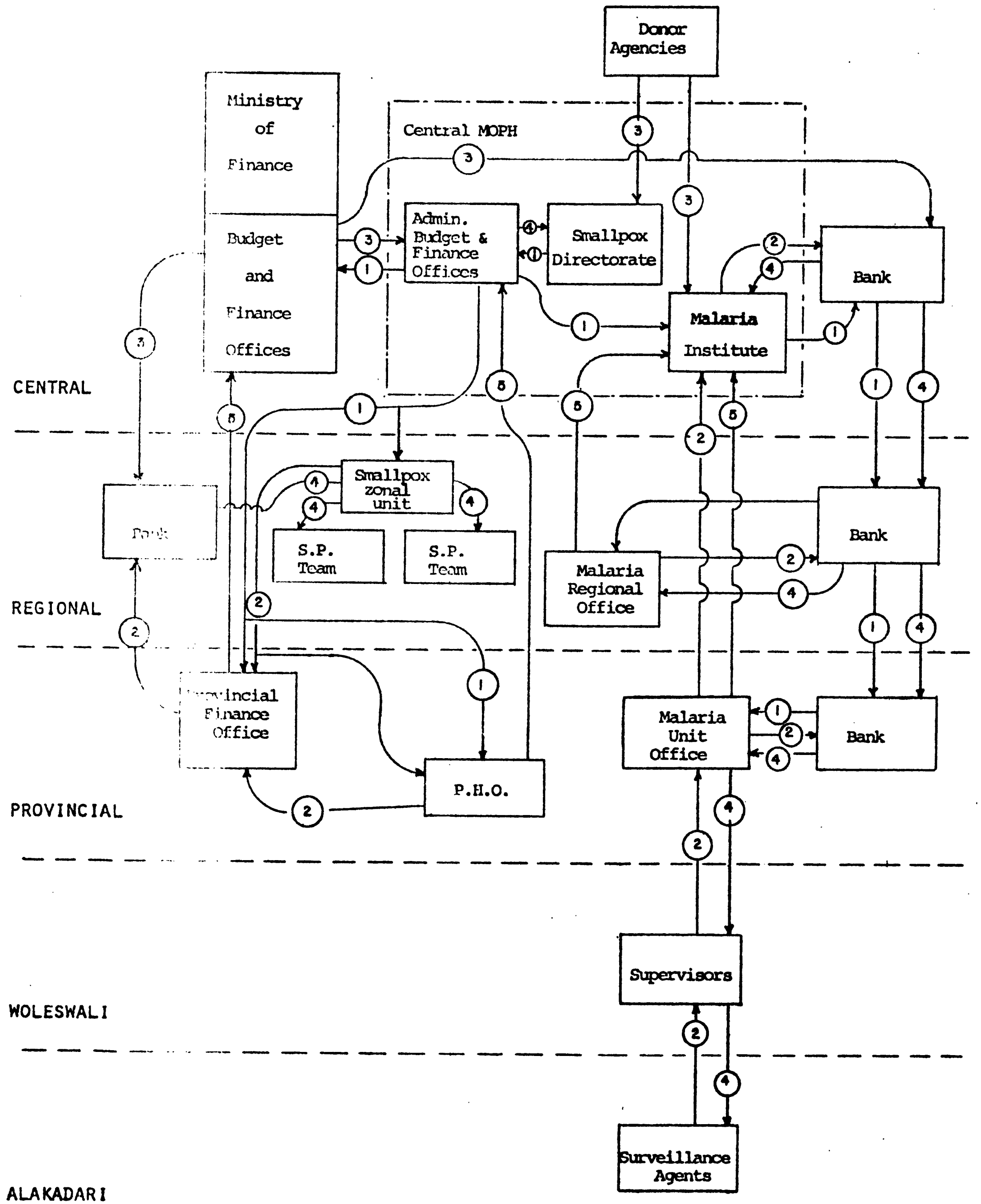
7b. Monthly, Provincial Mostafiat aggregates and sends to central MOF and MOPH.

7c. Monthly, local health facilities report expenditures through PHO to the MOPH, who forward report to MOF.

8. Occasionally, BHC's make special requests to PHO, who either deals with them himself or, more commonly, refers them to the MOPH.

Figure 3.3.2

MALARIA AND SMALLPOX FINANCIAL TRANSFER PROCESS



(1) →

__Yearly__, __Admin.__ informs the Smallpox and Malaria Programs of budget allocation.

__Quarterly__, Smallpox requests __Admin.__ Department to transfer funds via Ministry of Finance. Admin. informs Smallpox zonal unit, P.H.O. and Provincial Finance Office of transaction.

__Quarterly__, Malaria Institute __informs__ bank (central) to transfer funds to regional and unit offices. Bank informs offices when transfer completed.

(2) →

__Monthly__, Smallpox Zonal Unit requests cash funds via P.H.O. and P.F.O.

__Monthly__, Malaria Regional and __Unit__ Offices request cash funds direct to bank.

(3) →

Ministry of Finance arranges financial transactions with banks for Smallpox and Malaria cash funds.

For Smallpox Directorate (Kabul) funds via Admin. (MOPH)

(4) →

Cash flow from banks to field units.

(5) →

__Monthly__, P.H.O. informs central __Admin.__ of Smallpox expenditures.

__Monthly__, P.F.O. informs Ministry __of Finance__ of Smallpox expenditures.

__Monthly__, Malaria regional and __unit offices__ separately inform central Institute of respective expenditures.

3.3 BUDGET AND FINANCE

3.3.1 OVERVIEW

The MOPH, as a large, geographically dispersed organization, requires funds for:

a) Centrally-paid capital costs, such as land, buildings, and major equipment in support of central and local operations

b) Central Ministry operating expenses, such as administrative salaries and supplies, etc.

c) Centrally-procured supplies for use in local health operations, such as medicines, medical equipment and office supplies.

d) Locally-disbursed expenses, such as field staff salaries, etc.

To be effective, these funds must be available in the right amount, at the right time, in the right place. Achieving this rational coordination requires the organizational ability to plan future financial needs accurately, to obtain those funds as planned, to transfer funds appropriately to all levels of the MOPH, and to maintain the necessary control and accountability.

In the light of these needs, this section will briefly describe and analyze the present budget and financial activities of the MOPH in terms of:

a) Financial planning
b) Acquisition of funds
c) Transfer of funds
d) Financial records and controls

Figures 3.3.1 and 3.3.2 present a diagrammatic summary of these processes for the BHC system and for the Malaria and Smallpox programs, respectively.

3.3.2 DESCRIPTION OF ORGANIZATION AND PROCESS

3.3.2.1 Types of Budget

Most Ministries in the RGOA, including the MOPH, utilize funds from two separate budgetary sources. The Development Budget, administered by the Ministry of Planning, is intended primarily for infrastructure investment. Typical uses would be Health Center construction and furnishing, and major items of medical equipment. The other source of funds is the Government's Ordinary Budget, administered by the Ministry of Finance. This budget is used primarily to cover the operating expenses of Government programs, such as salaries, supplies, and rental charges. In practice, the clear distinction between operating expenses and capital investments is not always adhered to.

3.3.2.2 Financial Planning

3.3.2.2.1 Five Year Plans

Formal long-term planning takes place largely within the context

of the Nation's Five Year Development Plans (discussed in this report in Section 3.6: Planning). In brief, the Five Year Development Plans are prepared on a sectoral basis by all Government Ministries. They include an enumeration of major activities and expected accomplishments, and the capital budget requirements to carry out each program.

3.3.2.2.2 Annual Ordinary Budget

The Ordinary Budget of the MOPH is normally compiled by the Ministry's Administration Department, with little involvement by the operating Departments. Most budgeting for the health center system is done on the basis of standardized or known costs or allocations. For example: standard medicine and supply allocations are used for BHC budgeting; salaries are determined by corresponding civil service grades; rent obligations are known in advance to the Administration Department; etc. The drug and medicine component for the entire Ministry is determined by the Curative Medicine Department, which then formulates and administers this budget category.

Once these Ordinary Budget decisions have been made, the Administrative Department informs the Provincial Health Officers of the annual budget provision for their province. Subsequently,

the Administrative Department at the beginning of each quarter informs the PHO and the PFO of their actual allocations for the coming three months, based on the availability of funds, and the completion by the province of the necessary paperwork.

Allocation of the Provincial budget between the various local health facilities is currently performed by the PHO, who informs the facilities and the Provincial Finance Office of his decision. The PFO in turn advises the local Finance Offices in each Woleswali, to prepare them for the disbursements they will have to make. The Ministry is now planning a centralized allocation process, giving the Administration Department the responsibility for budgeting down to the Health Center level.

Donor funds are handled separately, based upon annual MOPH donor agreements referred to as Basic Assistance lists. However, with the major exception of WHO support for the smallpox program, in which a large part of the assistance is in the form of per diem payments to the field workers, assistance is mainly in the form of equipment, supplies, and fellowships, with little cash being given directly.

3.3.2.2.3 Annual Development Budget

This is set entirely at the central level, with no provincial involvement. An attempt is made to relate it closely to the provisions of the Five Year Plans.

Several steps are involved in planning annual development expenditures. An initial memorandum from the Ministry of Finance to the MOPH's Planning and Coordination Department is copied and forwarded to the other departments, requesting budget estimates. These are collected by the P & C Department, aggregated, forwarded for approval by the Minister of Public Health, and transmitted to the Planning Department of the Ministry of Planning. Subsequent negotiations between the MOP and the MOPH result in an agreed budget for approval by the Council of Ministers and the President of the Republic. The final decision is then transmitted back to the MOF, the MOP, and to the MOPH P & C Department which in turn informs the Administration Department. Little reliable data is available to the Administration Department from the Ministry's Construction Bureau on which to base estimates of capital requirements. The Administration Department generally over-estimates the amount which can be accomplished, and hence the funds required, leading to loss of MOPH credibility with the Planning Ministry.

3.3.2.3 Acquisition of Funds

In general, Ministry programs frequently do not actually receive all of the funds approved in the annual budget. There are three major reasons for this to happen:

a) The total National Budget fully allocates anticipated national revenue. Actual revenue may well fall short of expectations, sometimes by a considerable amount. In such cases, expenditure must be reduced correspondingly, and programs in the health sector are likely to have their funds curtailed. This is particularly true of those programs whose support contains a large component from the Development Budget, as this is the first to be cut back.

b) Priorities among Ministries, or within the MOPH, may change during the year, and be reflected in an actual allocation of funds that differs, perhaps substantially, from the amount budgeted.

c) Before funds are actually acquired by a program, certain administrative requirements must be met, particularly the appropriate documentation of expenditures in the previous quarter. If a program has been unable to spend its previous

allocation, or has not completed the necessary paperwork, it may lose some or all of its next allotment.

3.3.2.4 Transfer of Funds

Since the Development Budget is expended entirely at the central level, the transfer of funds primarily involves the ordinary budget, portions of which must be available, at specific times, at the local level.

The mechanisms for achieving this transfer differ substantially between the BHC, Smallpox and Malaria programs. For the Basic Health Center system, funds are transferred to the local level through Ministry of Finance channels, based on the planning phase described above. Each time that funds are actually required in the field, a written request is submitted to the local Woleswali Finance Office, which disburses cash directly to the health personnel. Payments for rent, etc., to third parties thus are paid by local health staff, rather than by the Finance Office. Extensive documentation is required before funds will be released for repairs or locally purchased supplies and equipment. In fact, any required expenditure which has not been explicitly included in the budget is extremely difficult for the system to handle.

3.3.2.5 Financial Controls

Here again, control over expenditures related to the Development Budget, which are entirely central, is relatively straight-forward Local operating expenses, predictably, are a more complicated matter. At the Woleswali level, the documentation on health expenditures is aggregated by the Finance Office, and reported through the Provincial Finance Office to the central Ministry of Finance and the MOPH. Since the Finance Office maintains these source documents, it, rather than the Health facility, is subject to Government audit. The MOPH receives an additional report each month directly from each local health facility, detailing its expenditures, and shares this data with the central MOF. While this might seem to provide for adequate control, a recent attempt to determine the actual figure for drug expenditures resulted in major disagreement between the GMD, the Department of Curative Medicine, and the Administration Department. Other attempts to provide specific items of information on past financial flows confirm that, at minimum, the cumbersome nature of the record and reporting system does not lend itself to supporting administrative analysis or financial planning.

3.3.2.6 Other Health Field Programs

The Financial systems of the Malaria and the Smallpox programs differ in important respects from that of Basic Health Services. Their relatively concrete and detailed work programs contribute to this difference, as supply usage rates, equipment requirements, maintenance costs, etc. are known in advance in much more detail, allowing more realistic financial planning.

Both programs utilize the services of Afghanistan banks at the Provincial level, rather than MOF channels, for the transfer of funds to the field, providing advantages of speed, flexibility and somewhat reduced paperwork. This approach is made feasible by the fact that field supervisory personnel are located in Provincial capitals, with reasonable access to banking facilities. As mentioned previously, Figure 3.3.2 outlines the Budget and Financial systems for these two programs.

Vaccine and Sera Institute is an institute already functioning under the financial auspices of the Public Health Institute. An enlarged, independent institute is under construction, with an estimated capital development cost of 200,000,000 afs. (about $3.3 million). At this point, the financial accounting for this project appears to be outside the MOPH budgets and channels as described here.

The General Medical Depot, another MOPH subunit, purchases approximately $200,000-250,000 worth of drugs annually, principally to supply government programs. The GMD budget and financial flows also appear to be outside the MOPH channels described to date, and are not fully understood by the Team at this point.

3.3.3 ANALYSIS

While our brief exposure to date to the RGOA financial systems undoubtedly does not do justice to an area of such complexity, major problem areas are so clear that they can be identified rapidly, and indeed are only too familiar to the MOPH. Moreover, critical resource limitations make these budget and financial problems of vital importance at present.

3.3.3.1 Financial Planning

The majority of the difficulties in financial planning can be attributed to four causes:

a) Lack of adequate supporting information

Decisions on financial input requirements are made without sound knowledge of current status or future needs.

b) Lack of clear policy guidelines and priorities

The MOPH is still feeling its way in attempting to meet the country's health care needs, and this is reflected in unclear objectives and strategy. Without these, however, Departments cannot propose rational budget estimates, and the proposals which are submitted cannot be rationally evaluated and acted upon.

c) Basic Complexity of the Health System

Financial planning by its very nature involves the fundamental process of allocating scarce resources between competing needs. In the context of health care programs, this unfortunately proves to be an extremely difficult problem, and one that no country, developing or developed, knows precisely how to solve. Furthermore, in Afghanistan, much of the supporting basic analysis that could shed light on the questions has simply not yet been attempted.

d) Lack of an Organizational Focus for Financial Planning

Most of the financial planning decisions are initiated within individual departments, and completed by a Ministry committee which meets for a very short time. There is no ongoing office or group within the Ministry, with a broad technical and managerial perspective, which can expend the great deal of time and effort necessary to develop adequate financial plans. The group which is needed would posses the technical skills to evaluate each Department's past and potential contribution to overall MOPH objectives. It would also have the analytic skills to examine a Department budget request critically, and summarize the findings for Ministry decision-makers.

3.3.3.2 Acquiring Funds

The problems in actually acquiring funds which have been budgeted result generally from causes beyond Ministry control, although purely administrative barriers, such as excessive paperwork could be alleviated. Even more important would be to develop contingency plans in advance, to guide Ministry action in the face of funds shortage during the year, ensuring that critical programs are safeguarded.

3.3.3.3 Transfer of Funds

With respect to the transfer of funds to the local level, the issue of local flexibility is important. In particular, the current authority of the PHO to allocate funds as he sees fit between health facilities in his jurisdiction has much merit, allowing him to solve problems locally, based on up-to-date information about local conditions. There is, of course, the corresponding danger that the actions he takes will not be in accordance with overall Ministry priorities. The key to solving this dilemma does not necessarily involve taking away his authority. An alternative solution worth considering would be to increase his accountability for his actions, by improved reporting systems on actual expenditures,

and clearer guidelines for him to operate within. Another important opportunity is that of learning from the Smallpox and Malaria Programs' experience in fund transfer through the banking system, to determine whether this approach could usefully be adapted to the needs of other programs such as Basic Health Services. In general, further analysis of the financial system is indicated to identify more clearly the bottlenecks in the transfer process.

3.3.4 Financial Control

This area similarly requires a more extensive analysis, particularly to improve the quality of financial reporting. A key step in this improvement would be to increase the involvement of the operating Departments such as Preventive Medicine in the financial system supporting their own activities.

3.3.5 Financially Attractive Program Alternatives

As a final note, we might suggest that in situations as financially strained as are present MOPH programs, most serious consideration should be given to exploiting opportunities which utilize health-providing resources that the government does not have to support

directly with salaries and facilities. Examples might be the use of the pharmacy system, and rural health practitioners who can largely support themselves, who can much more regularly reach the mass of the public, and who require only basic training, access to supplies and supportive government policy guidance.

As a corollary to the above, the MOPH should closely consider revenue-generating projects which are within its health mandate, such as may be represented in the generic drug initiative. A soundly structured Ministry enterprise, perhaps in cooperation with the private sector, could serve to bring appropriate medications to the people at reasonable prices, with a decreased foreign exchange drain, and perhaps even generate revenues to support health activities.

3.3.4 RESPONSES TO SELECTED OPPORTUNITIES

Subject to the interest and approval of the MOPH, we would recommend the following Team activities to address these problems:

3.3.4.1 Budget Formulation

Assist the Ministry with the background analysis and preparation for the annual budget cycle in the coming year. Team activity would focus on development of a systematic approach to annual financial planning, and on-the-job training in budget analysis. In the next year, the team would follow up and make necessary revisions, leading to identifiable improvements in the Ministry's budget process.

3.3.4.2 Financial Flows

Complete the analysis of MOPH financial flows, particularly those related to Rural and Family Health, recommended improvements in the design of these flows, and assist the Ministry with pilot testing and full-scale implementation of desired changes.

3.3.4.3 Financial Reporting

Assist the Ministry with the design of improved financial reporting processes to enable the operating Departments, and the BHS in particular, to exercise improved control over their own budget and financial flows.

3.4 TRAINING

3.4.1 Overview

3.4.2 Existing Organization and Processes

3.4.2.1 Central Organization

3.4.2.2 Other levels of training

3.4.3 Analysis and Problems

3.4.3.1 Organizational structure of training

3.4.3.2 Broader health sector for planning for training

3.4.3.3 Monitor and adapt current program

3.4.3.4 Lack of professional trainer

3.4.3.5 Lack of specific department training program

3.4.3.6 Arbitrary personnel shifts

3.4.3.7 Shortage of materials

3.4.4 Selected Responses to Opportunities

3.4.4.1 Training office

3.4.4.2 Training in MOPH procedures and simple management techniques

3.4.4.3 Field training - work programs and work manuals

3.4.4.4 Specialized international training

3.4.4.5 General approach to training program work plans

3.4. TRAINING PROGRAMS

3.4.1 OVERVIEW

With the development of new and revised procedures within the MOPH must come a commitment to effectively incorporate these procedures into the system of health care delivery. Only through an ongoing, permanent training mechanism can the Ministry hope to develop and sustain a cadre of personnel capable of delivering rural and family health care.

Initially it will be necessary to design and implement an intensive central (Kabul) training program to give Ministry personnel a broad-based understanding of Ministry programs and the management functions necessary to execute them: personnel, materials management, budget and proper flow of service statistics. To extend this training to regional and provincial field centers, training and supervisory teams will be required to initiate a constant flow of information and procedures.

Some specialized practical training abroad for program planning, training and general management will be indicated to give the Ministry expertise at the highest level.

3.4.2 EXISTING ORGANIZATION AND PROCESSES

3.4.2.1 Central Organization

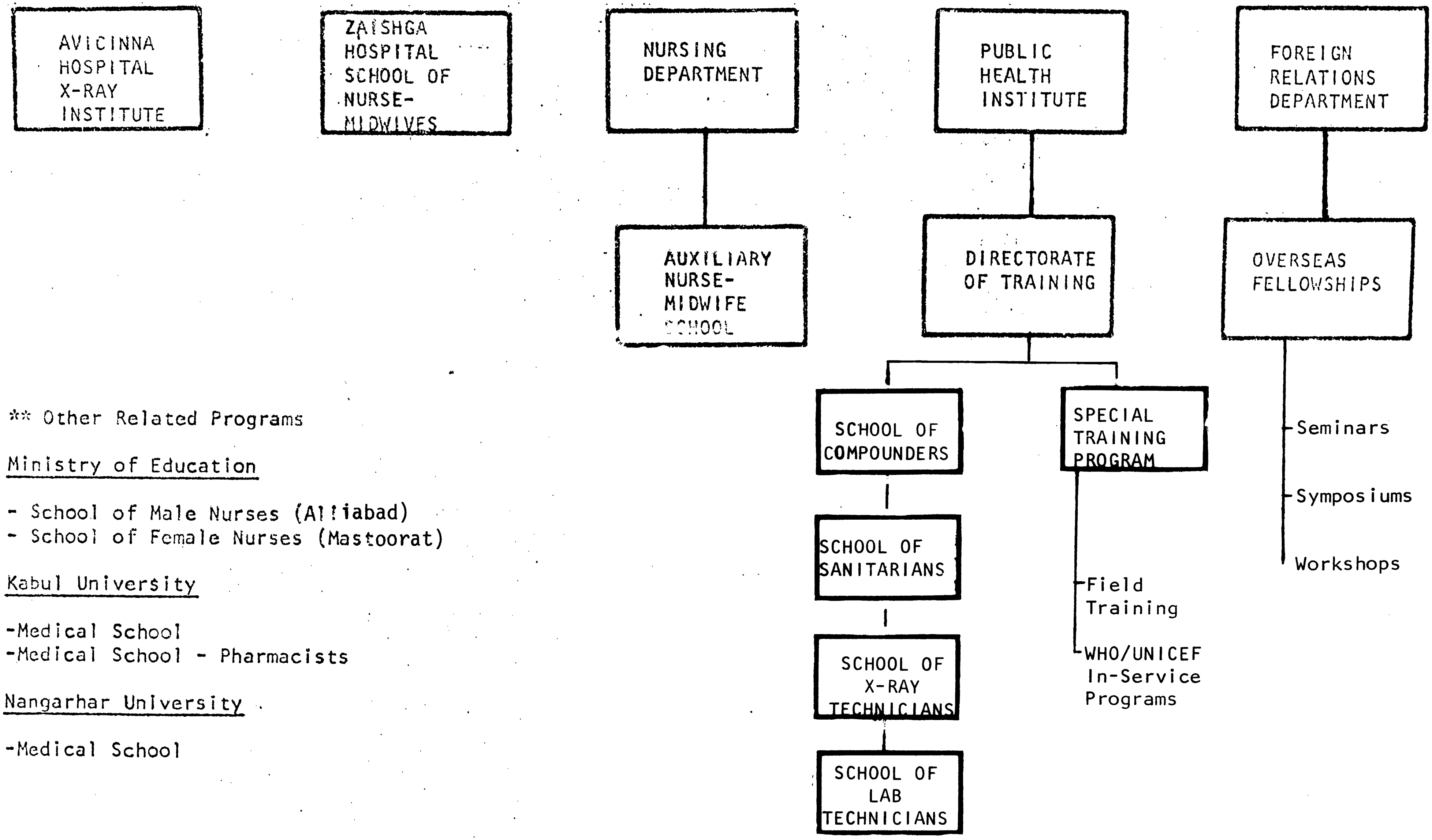
The training function in the MOPH is primarily delegated to the Public Health Institute (PHI), which is supposed to plan for the needs of various departments through a committee composed of PHI, WHO, Department of Curative Medicine, Department of Preventive Medicine, Kabul University, and Ministry of Education representatives. The committee meets twice a year to assess plans and problems presented by Ministry departments, peripheral training schools and programs.

Within the PHI, the Training Directorate acts as a coordinator for the schools under the PHI (for compounders, X-ray and lab technicians, sanitarians and auxiliary pharmacists) and for in-service training programs planned by any MOPH department. The Training Directorate includes a Director and 7 staff members who handle administrative detail.

Overseas Training and Fellowships originate largely from WHO and UNICEF. The WHO procedure is to provide funds in specific health areas (such as environmental health, laboratory procedures, or family health) which may be allocated for a variable number of participants and programs depending on

FIGURE 3.4.1

LOCAL TRAINING PROGRAMS UNDER THE MINISTRY OF HEALTH



** Other Related Programs

Ministry of Education

- School of Male Nurses (Aliabad)
- School of Female Nurses (Mastoorat)

Kabul University

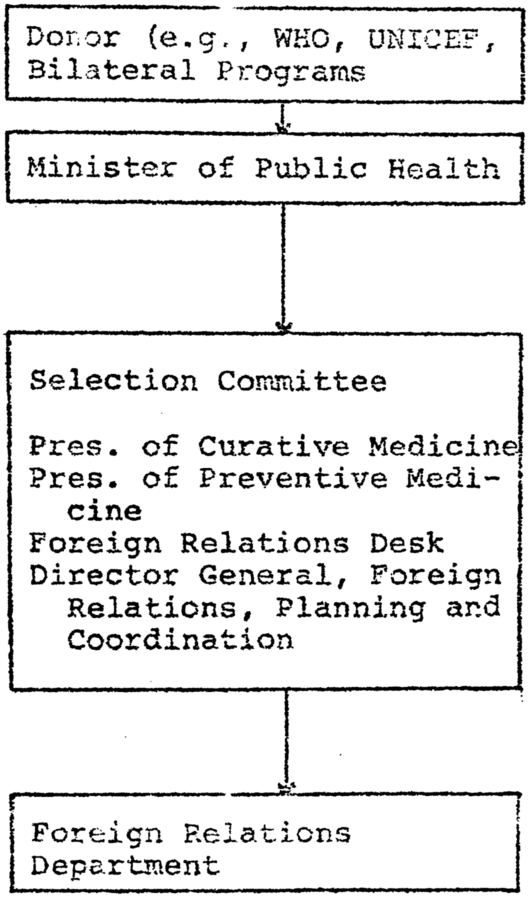
- Medical School
- Medical School - Pharmacists

Nangarhar University

- Medical School

Figure 3.4.2

SELECTION PROCESS FOR MOPH OVERSEAS TRAINING PROGRAMS



A proposal for a candidate to be sent to a seminar, fellowship, symposium or workshop from a donor group or based on a bilateral agreement is sent to the Minister for the selection of a candidate. The Minister normally sends it to the Selection Committee but can make the selection himself directly.

The "Selection Committee" selects a candidate or may send the proposal to a specific group (e.g., Child Health Institute) for selection of the best candidate

The selection is sent to the Foreign Relations Office to prepare a proposal on the individual candidate. After final approval, Foreign Relations prepares all visas, passport, and GOA documentation.

Under the current system there is no other ministry involved, but previously it was necessary for Foreign Relations to seek security clearance with the Ministry of Interior.

course availability and cost. Infrequently, the MOPH or the Ministry of Planning (MOP) may formulate a request for specific overseas training. Administration of overseas training is handled solely by the Foreign Relations Desk in the MOPH.

Figure 3.4.1 summarizes existing training programming by responsible MOPH department. Figure 3.4.2 summarizes the selection process for MOPH overseas training.

3.4.2.2 Other Levels of Training

Other training programs are carried out under general Ministry direction for:

Auxiliary Nurse Midwives	- Kabul ANM School
Nurse-Midwives	- Zaishgah Nurse Midwifery Program
X-Ray Technicians	- Avicinna X-Ray Institute
Malaria Workers	- Malaria Institute
TB Workers	- TB Institute

3.4 TRAINING PROGRAMS:

3.4.3 ANALYSIS

Seven major problem areas cause the MOPH to fall short of its goals in the training process. These are:

1. Organization structure of training in the MOPH
2. Need for broader Health Sector Planning for training
3. Ability to monitor and adapt training activities to meet the current program focus
4. Lack of professional "trainers" to assist in disseminating training techniques and to assist with program design
5. Lack of specific training programs in management and administrative procedures
6. Frequent and arbitrary personnel shifting within the Ministry
7. Shortage of training materials and class facilities

3.4.3.1 Organizational Structure of Training in the MOPH

The central training activity for the MOPH is channeled through the Public Health Institute (PHI). Others involved in the training process may be separated into two categories:

a) Training Institutions

Zaishgah Maternity Hospital

b) Institutions providing In-Service Training

Malaria Institute
Smallpox Program
T.B. Institute

The PHI is not presently staffed, administratively equipped, or empowered to handle the entire Health Sector training process.

The PHI is presently staffed by a group of technical personnel and the Training Directorate that handles the administration of the internal schools for compounders, X-Ray and lab technicians, sanitarians, and auxiliary pharmacists.

When it comes to training programs, one often hears, "The PHI will handle it." However, in fact the PHI may neither be able to handle it, nor be the best place to plan to handle it. Remaining gaps in the current training process are the intermediate planning steps: (a) evaluating how, when, where, and by whom the program is best carried out to meet the goals of the Ministry; (b) monitoring the program's design, development, implementation and results. The team believes that this would best be accomplished by establishing a Training Office under the Planning Board.

3.4.3.2 Broader Health Sector Planning for Training

There is no office within the MOPH that regularly addresses, at the direction of the Minister, over-all planning issues for training. The Minister frequently has to work with unreliable information that may fail to take into account all aspects of updated program plans, manpower, school enrollment, teacher availability,

etc. There is nowhere within the Ministry a compendium of current, accurate information that describes the programs planned, in progress, and completed, and their relation to requirements for short-term and long-term manpower development. The inconsistencies resulting in MOPH training actions contribute substantially to the inefficient and ineffective use of manpower and financial resources.

3.4.3.3 Program Monitoring and Adaptation of Training Activities to Meet the Current Program Focus

The current inability to evaluate ongoing training programs permits programs to go astray without corrective action. As an old need is satisfied, or when a new MOPH direction evolves, there is no appropriate means of communication with each of the various training resources.

3.4.3.4 Lack of Trainers to Assist in Disseminating Training Techniques to Effectively Meet the MOPH Goals

Training programs throughout the MOPH hinge almost entirely upon a few individuals' abilities to design, develop and implement a training program. In some cases the work may be very good, entirely depending on the chance that one of the most capable individuals may be involved. The Training Directorate of the PHI is not

staffed to provide specific training assistance - especially to field programs, and there is a lack of specialized training skills to efficiently manage the training operations.

3.4.3.5 Lack of Specific Training Programs

No internal procedural or administrative training process exists in the Ministry. There is a definite need to train Ministry personnel in Ministry procedures, based on specific job descriptions and approved Ministry processes.

a) Management: There is a need to introduce simple management principles common throughout the world to key Ministry personnel. Within the framework of these principles, MOPH personnel can attack problems from a shared base of understanding.

b) Administrative Procedures: As reviewed in the Materials Management Section (3.2), procedures are frequently ill-defined and unknown from department to department. The current and revised procedures will have to be conveyed throughout the Ministry to insure their adoption and efficient use.

3.4.3.6 Frequent Shifting of Personnel within the Ministry

The MOPH cannot afford to train personnel for a specific job or technical area and then transfer them, on the basis of personal influence, without regard for Ministry need. The pressures that from time to time cause transfers and shifting of personnel cannot be discounted, but these pressures do destroy continuity in programs and often set back what little progress has been made.

3.4.3.7 Shortage of Training Materials and Classroom Facilities

Lack of coordination and effective utilization of local and donor provided materials hinders the classroom programs from maximizing teaching potential. Recently, classroom space planned for an organized training effort has been diverted for offices and residential use.

3.4.4 SELECTED RESPONSES TO OPPORTUNITIES

The MOPH has given considerable verbal priority to training since the founding of the new Republic. The plan of activities which follows from this priority includes:

3.4.4.1 A Central MOPH Training Office

The establishment of a training office within the Planning Board is the first necessary step toward effective health sector training. It must monitor existing technical and manpower training programs and provide an information and decision-support channel to the Planning Board and minister on a regular basis. It will initiate the design, development and implementation of new management, procedural and rural health care training in cooperation with WHO and other groups. As the planning and control center into training, this activity should directly deal with the problems noted in parts 3.4.3.1 - .3 above.

3.4.4.2 Training in MOPH Procedures and Simple Management Techniques

Simple internal training programs to communicate administrative procedures, orientation material to MOPH objective and programs, and simple approaches to organized problem solving will be designed and implemented by the Training Office with Management team support, addressing problem 3.4.3.5.

3.4.4.3 Field Training - Health Center Work Programs and Work Manuals

While general MOPH policies, health plans, and technical job descriptions exist in the five year plan and advisory materials, there is little effective transfer of either the administrative or technical health content into practical form for the health worker's organization of daily activities in the field. Two project activities address this problem, Health Center Work Programs and Health Worker Manuals:

a) Health Center Work Programs

Given a set of health center objectives and work areas such as Family Health, Communicable Disease Control and Environmental Health, the Management Team will work with MOPH and advisory staff to develop simple procedures to structure health center work activities between clinic-centered (e.g. Family Health days, polyclinic days and administrative days) and field-oriented activities (e.g. scheduled field visiting for ANM's, Vaccinators, Sanitarians and lab-technicians.)

Practical division of authority and responsibility among health center personnel is another dimension; specifying which personnel are authorized to perform which services with access to which supplies and equipment. The Health Center

Work Program idea is an important practical tool to organize staff time around priority tasks and provide an objective basis for supportive supervision and management control.

b) Health Worker Manuals

In terms of training, Health Center workers have been traditionally at the end of the line. In a real sense, they have the most difficult jobs: they work under the most difficult circumstances, with the most limited resources and education while having to deal with all the community's expectations. One approach to helping rural health workers deal with these problems is to provide each with a manual which details in simple language, diagrams and pictures of both the administrative and technical health aspects of their jobs.

The Administrative Section of this Health Worker Manual will contain summaries of health center and MOPH organization and objectives as well as the required procedures, reporting channels and divisions of responsibilities.

The Technical Health Section will contain simple step-by-step procedures to identify and deal with the health problems that comprise the majority of the health worker's activity.

FIGURE 3.4.3

OVERSEAS TRAINING PROGRAMS

TRAINING PROGRAM	1974				1975				1976				1977				NO. PARTICIPANTS TRAINED
	I	II	III	IV	I	II	III	IV	I	II	III	IV	I	II	III	IV	
Personnel Administration			1				2		1								4
Management Analysis											1						1
Family Planning Trainees							2*				2*						4
Trainers of Trainers			2										2				4
Financial Management					2												2
Project Management					2				2				2				6
Materials Management					1				2								3
																	24

*Funded by AID/W Contract with DATP

In view of limited educational experience and available technical supervision, the problems and procedures will be outlined as they commonly present (e.g. "pregnant", "post partum", "fever", "diarrhea", "cough", etc.) with actions and treatments specified in terms of available health center drugs and supplies. Work is in progress with MOPH and WHO technical cooperation and Appendix 5 includes an example of a subset of these materials, dealing with pregnancy, post partum and family planning actions by auxiliary health workers.

As a vehicle for continued in-service training, the Work Manual concept should foster supportive supervision and feedback for rural health workers, and the potential justifies a major development effort.

3.4.4.4 Specialized Training

In general while most training will be appropriately done in Afghanistan in the near term, key individuals will be sent abroad to receive short-term practical training initially in 3 areas: training of trainers, financial management and materials management. Figure 3.4.3. outlines the time phasing of specific overseas training anticipated.

3.4.4.5 General Approach to Training Program Work Plans

As specific training needs are addressed, the following series of tasks will be completed by MOPH personnel and the Management Team to assure adequate planning, documentation, and MOPH clearances:

PHASE	TASK
INVESTIGATION	I. Define the problem and planning necessary to meet the goals of the MOPH/MSH project. A. Review the training statement; confirm or redefine the statement B. Determine the approach for carrying out the training programs C. Develop an outline for the plan D. Obtain MOPH concurrence with the plan for attacking the training program.
INFORMATION ACQUISITION AND ANALYSIS	II. Training Data acquisition and analysis A. Gather information about the current training program B. Identify existing training systems 1. Components 2. Interface with Ministry C. Develop simple flow charts of training channels D. Analyze information, training data and flow charts E. Identify program problems F. Identify peripheral problems and requirements

3.4 TRAINING PROGRAMS: SELECTED RESPONSES

March 74

DESIGN

III. Training Proposals

A. Determine alternative training solutions
B. Determine a recommended alternative
C. Develop a defined design for a training system
D. Obtain MOPH concurrence with recommended solution
E. Obtain MOPH approval of training design plan

IV. Training Systems Design

A. Identify training system
   1. Components
   2. Interface with Ministry
   3. Required input
   4. Required procedures
   5. Required programs
   6. Procedural forms
   7. Required reporting
B. Prepare flow chart for new training system
C. Prepare plan for training system development
D. Obtain MOPH/AID concurrence with system design
E. Obtain MOPH approval of system development plan

DEVELOP

V. Training System Development

A. Develop training system component
B. Define Ministry's interface
C. Obtain:
   1. Required personnel
   2. Required procedures
   3. Required materials, equipment
   4. Required budget clearance

D. Prepare training implementation plan
E. Obtain MOPH approval of systems implementation plan

IMPLEMENT

VI. Training System Implementation

A. Instruction of training office staff
B. Assist in operating of new training system
C. Modify the training system as necessary based on operating experience
D. Implement the training system
E. Audit training operations after stabilization period

3.5 MANAGEMENT CONTROL - STATISTICAL DATA AND SUPERVISION

3.5.1 Overview

- 3.5.1.1 Overview of Statistical Data

3.5.2 Organization and Processes

- 3.5.2.1 BHS Statistical Data
  - 3.5.2.1.1 Monthly Output Service Statistics
  - 3.5.2.1.2 Monthly Input Service Statistics
  - 3.5.2.1.3 Quarterly Processing
- 3.5.2.2 Malaria and Smallpox Programs Statistical Data
- 3.5.2.3 Supervision

3.5.3 Analysis

- 3.5.3.1 Statistics and Data Management for Rural Health
- 3.5.3.2 Supervision of Rural Health Services

3.5.4 Selected Responses to Opportunities

- 3.5.4.1 Statistics
- 3.5.4.2 Supervision
- 3.5.4.3 Conclusion

3.5 MANAGEMENT CONTROL - STATISTICAL DATA AND SUPERVISION

3.5.1 OVERVIEW

For discussion purposes, Management activities are frequently divided into two major categories, planning and control.

The term planning refers to activities such as setting organizational goals, policies and objectives, and the term control refers to activities assuring that program operations actually meet program objectives, or taking corrective action when activities are not leading to the desired objective. While several of the MOPH Administrative operations discussed in Section 3 (including many aspects of personnel, materials management, budgeting and training) can be considered "Management Control" activities, the term "Management Control" is used here to refer primarily to the day-to-day documentation and monitoring of rural health services; that is, Management control of rural services through the use of statistical data and supervision.

3.5.1.1 Overview of Statistical Data

In the MOPH, health staff with managerial authority have responsibility for the decisions that allow a program to move forward. There are two major components to the information which the health worker may draw upon to support his decisions: objective information and subjective information. Both subjective and objective information are important, and the effective manager combines both in making the most appropriate decisions.

Subjective information for decision making, covering such important issues as judgment and sensitivity to the political and social

environment, is recognized as a vital link in the process, but is, by definition, not readily susceptible to analysis for this report.

The objective information component is perhaps typified by the label "statistical data", which in the MOPH context might be divided into three parts:

a) The status of the Afghan environment, with examples being the population, village and epidemiologic surveys by Afghan Demographic Studies, the CINAM team, and the Buck/Johns Hopkins Monograph, respectively;

b) The inputs to the health system, including personnel, money and supplies, described elsewhere in this report;

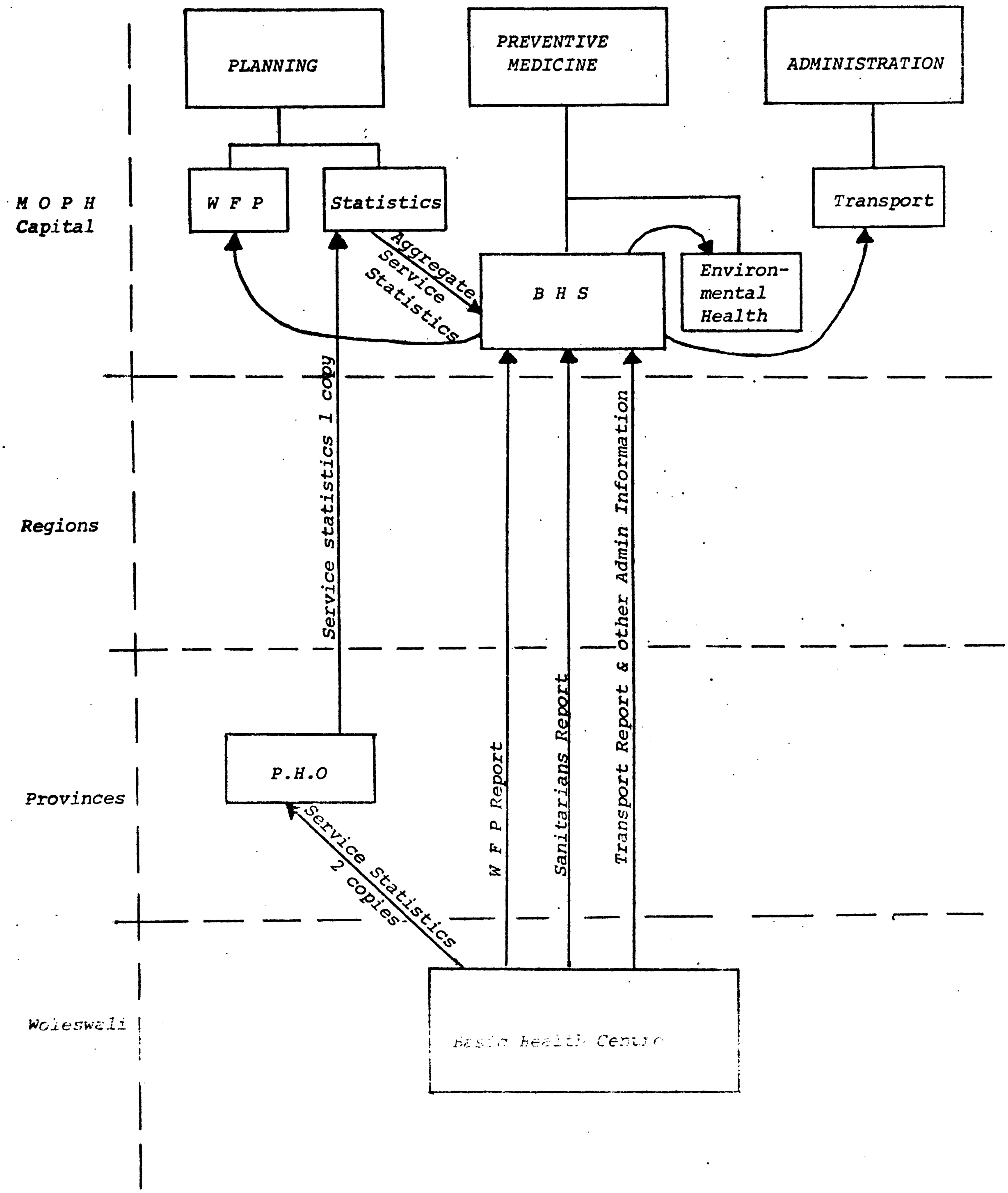
c) The outputs of the health system, such as discharged hospital patients, clinics held, patients seen, home visits made, personnel trained, or medications and immunizations given.

This section concentrates particularly on the third part, statistical data for decision-making produced by outputs of the health system, as data relating to inputs are addressed in the sections on Personnel (3.1), Materials Management (3.2), and Budget and Finance (3.3).

While this report concentrates on existing statistical data for the management of Rural and Family Health Services, the picture would be incomplete without recognition of hospital data (particularly in the gradual emergence of discharge summaries) and private sector data (particularly relating to the pharmacy system data, which is largely unavailable to the MOPH at present) as important elements for effective management of the health system.

Figure 3.5.1

Basic Statistical Data Flow



3.5.2 ORGANIZATION AND PROCESSES

3.5.2.1 Basic Health Services Statistical Data

Figure 3.5.1 outlines the routine statistical information flows established for Basic Health Services. At this time, some input and output statistics are relatively regularly gathered and forwarded to Kabul, though the health services do no vital data reporting (beyond hospital deaths).

3.5.2.1.1 Monthly output service statistics are collected by BHC staff on the forms included in Appendix 2. They include:

a) A Health Institution Report (Form 2-1) summarizing general clinic activity in terms of numbers of vaccinations, polyclinic, and MCH visits by age; deliveries; TB caseload; home visits and lab tests. Each BHC and hospital sends 2 copies to the PHO, who keeps one and forwards the other to the Manpower and Statistics Bureau in the MOPH Planning Section. Daily work sheets or clinic register sheets (Forms 2-2,3) are the basis of the Monthly Health Institution Report. Mother's and child's cards (Forms 2-4,5) are the individual health record.

b) An Environmental Health Report (Form 2-9) summarizes the sanitarian's activities, and is routed through the BHS Bureau to the Bureau of Environmental Health.

c) World Food Program (WFP) commodity distribution (Forms 2-6,7,8) registering mothers and children and summarizing the numbers

registered, amounts distributed and amount remaining, which is routed through BHS to the WFP office.

3.5.2.1.2 Monthly Input Service Statistics, including:

a) Vehicle status - the condition of vehicle and monthly mileage, routed by BHS to the MOPH Central Workshop;

b) Personal Attendance Record - retained by BHS;

c) Financial Flows, as noted in Section 3.2.

3.5.2.1.3 Quarterly Processing

Quarterly, the MOPH Statistics and Manpower Office totals the Monthly Institution Reports, obtaining summaries of polyclinic attendance, vaccinations, TB and malaria slides collected, home visits, and MCH visits for treatment, delivery, antenatal and postnatal care.

3.5.2.2 Malaria and Smallpox Programs Statistical Data

These programs - particularly Smallpox - are examples of reasonably well-conceived and managed service statistics and data management systems. They include:

a) Comprehensive reports on activity levels, work output per section, team and worker

b) Information needed to estimate program impact (effectiveness)

c) Data processing capacity (mainly hand processing)

d) Feedback of information to personnel responsible for followup and/or policy.

e) Some followup to correct problem or shortfalls.

In short, statistical data in these programs are given priority attention, and the results show it.

3.5.2.3 Supervision

As the human element in management control of rural health services, the supervision process is difficult to organize, unpredictable to deal with, but vital to any substantial gains in health delivery. Supervision of BHC activities takes place on three different levels - the Central Level, the Provincial Level, and the BHC Level:

a) Central Level: There are four regional supervisors at the central level, working under the direction of the Bureau of Basic Health Services. Each Supervisor has responsibility for all of the BHC's in a particular region.

The regional supervisors are assigned to Kabul, but it is planned that they should spend a large proportion of their time up to 40% - visiting each BHC once each quarter.

Regional supervisors report their findings on a regular basis to the President of Preventive Medicine and the Director of the Basic Health Services Bureau, both of whom are too busy to make field visits on a regular basis. This approach is brand new, and as yet really untried.

b) Provincial Level: The Provincial Health Officer, in principle, has supervisory responsibility for each BHC in his province.

c) BHC Level: The primary responsibility for the ongoing supervision of the BHC and its sub-centers lies with physician assigned to the center.

3.5.3 ANALYSIS

3.5.3.1 Statistics and Data Management for Rural Health

At this time, from a rural health services viewpoint, statistical data on the inputs to, and outputs from, Basic Health Services have not been used to support decision-making, in part due to the fact that low priority has been given to the process of data collection. There is little tradition of decision-making based on objective statistical information, perhaps because such information has not been available. The result of this low priority and resultant disorganized information management process is that the available data from rural health services:

a) Are incomplete, with less than half the units reporting in any given month;

b) Are tabulated and reach the Director of Basic Health Services three to six months after submission;

c) Are often grouped together with hospital data, making it difficult to use for rural health management purposes;

d) Are not fed back to the rural health units in any form that might assist their work or encourage evaluation of performance;

e) Are not regularly incorporated into the supervision process.

3.5.3.2 Supervision of Rural Health Services

Active supervisory support for rural health is an old idea, but a very new area for any concrete action. The four regional supervisors are new with no predecessors; they have no formal training; as yet there are no health center work programs or health worker manuals in use for staff to be measured by; there is no clear division of responsibility or authority between the Provincial Health Officer and the BHC supervisor with regard to control of the BHC system; there is no clear acceptance by the supervisors of both administrative and technical supervisory responsibility.

In view of these realities, it is understandable that, to date, supervisory efforts at management control of rural health activities have been arbitrary, uneven, and perceived by both sides as a largely punitive inspection procedure.

3.5.4 SELECTED RESPONSES TO OPPORTUNITIES

3.5.4.1 Statistics

If the MOPH is committed to making management use of statistics and information available on the inputs and outputs of MOPH programs, the primary requirement is to put a competent Afghan with an active interest in management in charge of the Statistics Bureau, with a minimum commitment period of two to three years. The waste of the relatively large numbers of statistically trained personnel who have been trained by WHO and others, and who are not posted in Statistics, requires very careful consideration by the MOPH. The Management Team strongly suggests that the MOPH take action on the use of statistical data to support MOPH management. Should the MOPH now be prepared to take action, subsequent steps include:

a) A working group of MOPH department managers to specify the data believed to be required to support specific program planning and program operation decisions, listing both clearly.

b) Analysis, by the MOPH Statistics Bureau Director, of the potential work, steps and time involved by both field and department staff, as well as Statistics Bureau staff, in the collection, processing and distribution of the information.

c) Recognition that limited resources require a decision by the Minister, or his appointed committee as to what priority each information task is to have for the Statistics Bureau, and recognition by MOPH department heads that requests with lower priority cannot initially be met by the Statistics Bureau.

d) Preliminary display and use of available BHC data, with feedback to BHC staff through reports and supervisory visits.

e) Design of simplified BHC reporting procedures, training of staff and implementation.

f) Early feasibility analysis of the potential role of automated data system components for rural health management control, to plan the statistical system to be compatible for eventual automation.

3.5.4.2 Supervision

A reasonable chance to improve rural health supervision requires many related actions, including continued development of the BHC supervision network operating from central offices through:

a) Completion of a statement of job authority needed by each supervisor in order to carry out his responsibilities.

b) Finalization of work programs for each BHC and work manuals for each BHC staff member, as the technical and administrative base for supportive supervision.

c) The final development and testing of route schedules and maps for each supervisor.

d) A period of practical on-the-job training including motivational training for supervisors, stressing the positive supportive nature of their roles and the importance of their role as a communication link between the BHC and the central office.

e) Assistance in the development of a plan to redesign the PHO's role to have a more direct supervisory responsibility for the operations of the Basic Health Centers in his province.

f) Continued study of existing models of supervisory systems in the country, including examples such as ADS Field Control Officers, Ministry of Finance and Interior supervisory systems, and the Smallpox and Malaria Programs.

3.5.4.3 Conclusion

The Management Team believes that an important need and opportunity exists to effectively develop the management control activities of the MOPH to support rural health development.

In the statistics area, the primary requirement is MOPH recognition of the usefulness and priority of this task, through the appointment of a competent Afghan director for a period of not less than two years. The Management Team, as part of its work plan within the MOPH, will provide management consultant support for the activation of a functioning Statistics Bureau, provided that such a commitment is requested by the MOPH and is in accord with the work plans of other assistance groups.

3.6 PLANNING

3.6.1 Overview

3.6.2 Description of Organization and Processes

3.6.2.1 The Planning Board

3.6.2.2 The Planning and Coordination Department

3.6.2.3 The Five Year Plan

3.6.3 Analysis

3.6.3.1 Planning Health Care Delivery System Output

3.6.3.2 Planning the Health Care Delivery Process

3.6.3.3 Planning Health Care Delivery System Inputs

3.6.3.4 Planning Health Care Delivery System Management

3.6.4 Responses to Selected Opportunities

3.6.4.1 Health Problem Definition

3.6.4.2 Identification and Analysis of Alternative Health Care Delivery Systems

3.6.4.3 Organizing for Planning

3.6 PLANNING

3.6.1 OVERVIEW

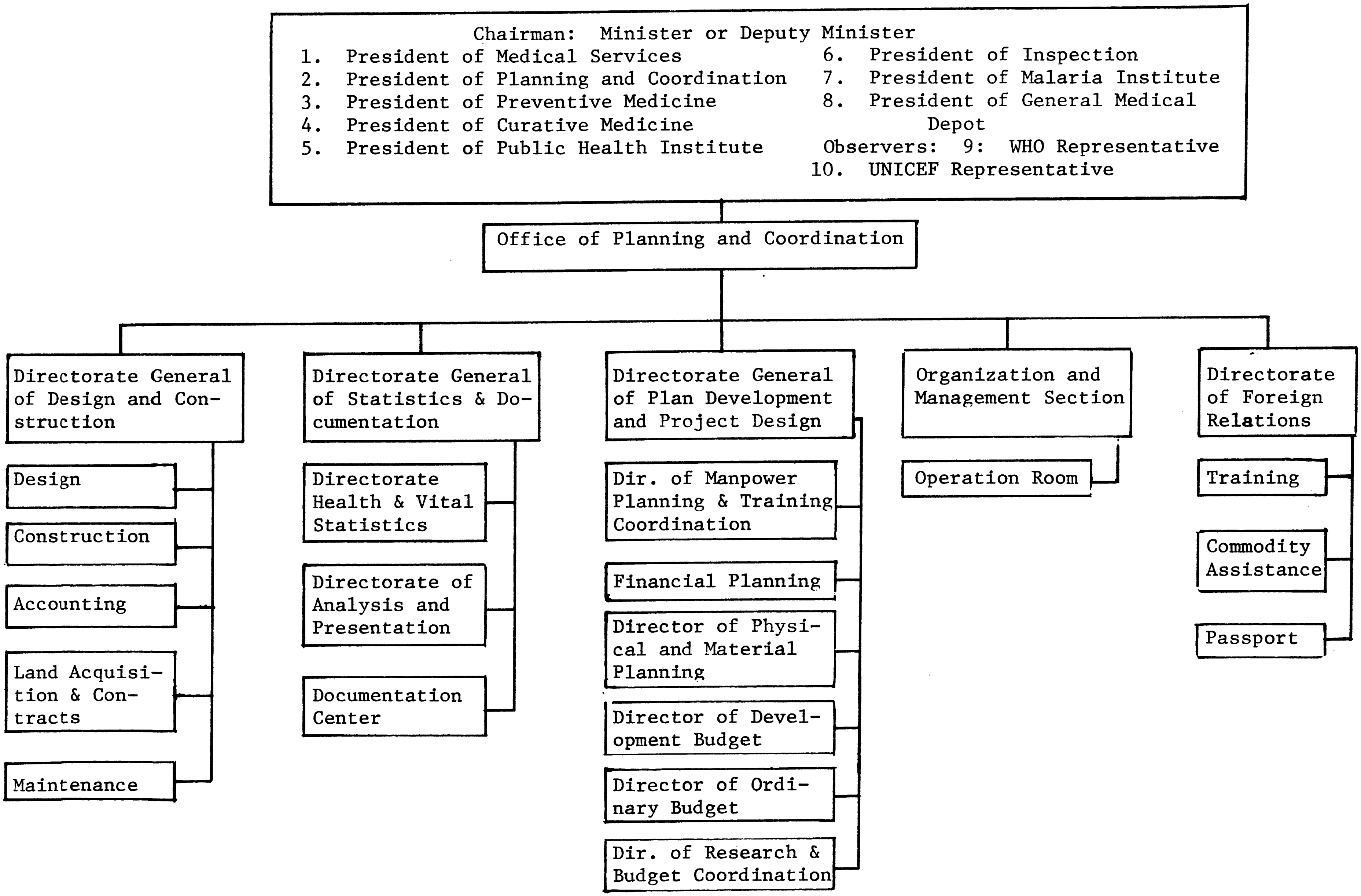
Although Afghanistan has had experience with national planning for many years, and the MOPH is now officially operating under the country's Fourth Five Year Plan, the MOPH is far from satisfied with its own efforts in health sector planning. Problems clearly attributable to insufficient planning arise constantly, resulting in emergency action which occupies valuable top management time and requires rapid resource reallocation.

Major characteristics of the current situation include a lack of coordination between health programs, and relatively ineffective use of Ministry resources, particularly those supplied by foreign donors. Both these problems arise directly from the inadequacy of the planning process.

In the terminology of "systems analysis", the major aspects of the health care delivery system are the delivery process, the resource inputs, the system results or outputs, and the management of the system. If the system is to be effective, all of these must be carefully planned. Planning of the systems inputs is largely covered as part of sections 3.1 through 3.5 This section will focus on the remaining planning tasks.

FIGURE 3.6.1

PLANNING BOARD



3.6.2 DESCRIPTION OF ORGANIZATION AND PROCESS

Despite the existence within the MOPH of a Planning Board, a Planning and Coordination Department, and the production of a series of Five Year Plans, a rational and organized planning process cannot really be said to exist.

3.6.2.1 The Planning Board (See Figure 3.6.1)

This group is composed of the Minister or Deputy Minister and Presidents of all Departments. Rather than being an active body for converting policies into development plans, and engaging in project review, it now rarely meets. This alone guarantees a low level of coordination and lack of adequate information or analytic support for the individuals who are faced with the key planning decisions.

3.6.2.2 The Planning and Coordination Department

They are primarily responsible for coordinating the projects which have been included in the Five Year Plan with the annual development budget. It plays an active role in this budget, serving as an interface between the MOPH and other agencies involved. However, it has only marginal amounts of information available to it regarding Ministry goals, present program levels, and physical and personnel requirements.

3.6.2.3 The Five Year Plan

The Five Year Plan in fact is little more than a simple aggregation of the descriptions and financial projections of assorted programs designed and supported by donor agencies. It stops well short of what might be considered a real development plan.

3.6.3 ANALYSIS

Evaluation of MOPH planning can be structured by considering each of the health delivery system aspects which must be planned.

3.6.3.1 Planning Health Care Delivery Output

No significant output planning is done at any level of the Ministry. At the field level, workers naturally lack the perspective to plan their level of accomplishment, and simply deal with patients as they arrive. A significant exception are the workers in certain highly structured programs such as Malaria Control, where individual workers are in fact made responsible for a certain amount of short-term planning and scheduling of their activities.

At senior Ministry levels, ability to plan output is seriously handicapped by the lack of useful data on health problems, which could form a basis for setting health care output objectives.

3.6.3.2 Planning the Health Care Delivery Process

Again, at the local level, no planning is attempted, and in general it is probably unreasonable to expect much iniative from field staff in this respect. However, Health Center physicians could certainly be trained and encouraged to explore and implement various individual approaches to the process of health care which meets the specific needs of their local community. Similarly, specifically trained staff such as ANM's could possibly be motivated to be more innovative.

Perhaps the greatest shortcoming in the entire planning area is the general absence of innovative analysis and design of health care delivery processes at higher levels in the MOPH. While this is certainly regrettable, it is also clearly understandable. Planning of this type requires the careful and detailed consideration of a range of alternative delivery systems, and this type of management activity requires extensive staff support. Such supporting analysis is not currently available in the MOPH. A major requirement then, would be the development with in the MOPH, presumably related to the Planning organization, of this analytic staff support capability.

3.6.3.3 Planning Health Care Delivery System Inputs

These processes have been covered under the individual sections 3.1 to 3.4, which deal with the planning and control of these resource flows.

3.6.3.4 Planning Health Care Delivery System Management

Although Ministry concern with management issues has only recently begun to appear in an organized fashion, questions of the structure and operations of the MOPH are constantly under consideration at senior Ministry levels. Important recent examples include the interest of the Minister's office in potential reorganization of the MOPH's overall structure and of the Planning function in particular, as well as the attempt by the Director of Basic Health

Services to develop effective supervisory mechanisms for his field program.

Clearly, the Ministry's interest in having the MSH team work closely with them is evidence of strong current interest in planning innovative ways to strengthen the MOPH's management systems.

3.6.4 RESPONSES TO SELECTED OPPORTUNITIES

The planning process is an area in which the Management Team has been given a particularly clear mandate to assist. The Team's activities will focus on the following problems:

3.6.4.1 Health Problem Definition

In the face of critical resource shortages, and recognition of important new foci of health services such as the maternal-child-family health unit, priorities are being examined and reviewed within the Ministry. As described at the beginning of this report, highly significant information sources have recently appeared which illuminate the related basic question of objective and perceived health problems. The challenge of relating this new knowledge systematically to the planning process is one which the team will attempt to attack.

3.6.4.2 Identification and Analysis of Alternative Health Care Delivery Systems

The major constraints of resource availability and physician service in remote areas can be addressed by carefully designed alternatives to the present delivery system model. Major opportunities exist to plan and test innovative approaches such as increased reliance on paramedical personnel, and direct stimulation of private sector facilities such as pharmacies. The Management Team's input would focus again on assisting Ministry decision-makers in identifying, analyzing and testing such alternatives, leading to a major thrust in the context of the next Five Year Plan.

3.6.4.3 Organizing for Planning

A final area of proposed Team involvement is support in the design and training of a new organizational resource in planning. This of course could only follow explicit Ministry action in moving to establish such an organizational unit.

4. STRATEGY RATIONALE AND SUMMARY OF PRIORITIES

4.1 RATIONALE

4.1.1 Opportunities and Needs

While the MOPH has the responsibility for planning and setting national health policy, the MOPH is not and cannot in practice be responsible for the direct operation of all health services. However, the Ministry's commitment to obtaining the maximum health benefit for the people, using all available public and private resources, can be more effectively met by using the leverage or power inherent in MOPH authority to make policy for all health activities, including the private sector. This is a major opportunity.

Priorities in the work plan must reflect this balance of opportunities in managing the development of rural and family health services. More specifically:

a) The existing, formal MOPH structure and procedures must be improved, as the only feasible national focus for planning and control of health needs.

b) The parts of the health system beyond direct MOPH staffing and operations will continue to represent the major health resource pool available to rural areas for the forseeable future, including the pharmacies and the village providers of health care, for example. Management support for MOPH analysis and policy planning for initiatives in this area has the potential for substantial leverage and real improvements in rural family health at minimal direct cost to the MOPH.

Figure 4-1

CONSIDERATIONS IN SETTING WORK TASK PRIORITIES

	NEED	OPPORTUNITY	CAPABILITY	LEVERAGE/ RELATIVE PAYOFF
PERSONNEL	High	Beginning phased input over next six months	OK	High
Materials Management	High	Now	Developing satisfactorily	High
& Generic Drugs	High	Developing	Careful MOPH development required	Very high
Finance & Budget	High	Planning Board	MOPH requires focus for budget planning	High
Training	High	Development of specific work plans & manuals for rural health workers	MOPH Training Office required to focus activities	High
Statistical Data	High	Present vacuum in leadership & low MOPH priority	Senior competent Afghan required. MSH would require additional team member	Medium/ High
Planning	High	Possible with a stabilized Planning Dept.	MOPH requires stability & senior competent Afghan in charge	High

4.1.2 Criteria for Setting Task Priorities

Four major considerations affect the priority assigned to each work task area: need, opportunity, capability and potential payoff or leverage.

a) Need: Is the work task perceived by the MOPH and by the Management Team as important for improved health delivery?

b) Opportunity: Is the timing appropriate, in terms of MOPH readiness to act upon the work now?

c) Capability: Can the MOPH, the Management Team and/or other inputs, commit the skills and personnel required to have an acceptable chance of succeeding with the task?

d) Relative Payoff or Leverage: How does the task compare with alternative tasks and uses of personnel time and skills? How much improvement in availability and use of appropriate health services is likely to result from the task?

Figure 4.1 summarizes the Team's interpretation of the interrelationships between these considerations of priority and the work task areas outlined in Section 5, the Work Plan.

4.2 SUMMARY OF PRIORITIES

In short, the Work Plan (Section 5) attempts to phase over time the work tasks required to:

a) Meet immediate MOPH needs for improvements in the basic MOPH operations necessary for rural and family health services.

b) Support analysis and implementation of MOPH policy initiatives that will exploit and involve resources in the private sector and other government activities.

5. WORK PLAN

March 74

5.1 DISCUSSION

As noted in Section 4, the Work Plan is a product of the dialog between MOPH leaders and the Management Team. It represents a summary judgement on the combination of activities thought to move most appropriately towards effective rural health development.

The Work Plan is presented in two formats. Figure 5.1 addresses the intermediate activities and processes required of the MOPH and the Management Team to achieve the desired outputs. These activities are summarised in terms of the MOPH Administrative Operations outlined in Section 3 of this Report: Personnel; Materials Management and Generic Drugs; Finance and Budget; Training; Management Control; and Planning.

Figure 5.2 outlines a schedule of anticipated outputs directly related to the delivery of rural services, in terms of trained staff in place, supplies available, the management control of rural health service delivery, and effective planning and budgeting.

The outputs and timetable outlined are contingent upon continued interest and commitment on the part of responsible MOPH and RGOA officials. The sequence of activities and timetable is possible, assuming that the MOPH makes the vital policy decisions noted in Figure 5.2 It is

FIGURE 5.1

MANAGEMENT SUPPORT FOR RURAL AND FAMILY HEALTH - AFGHANISTAN

WORK PLAN - PROCESSES REQUIRED TO ACHIEVE OUTPUTS

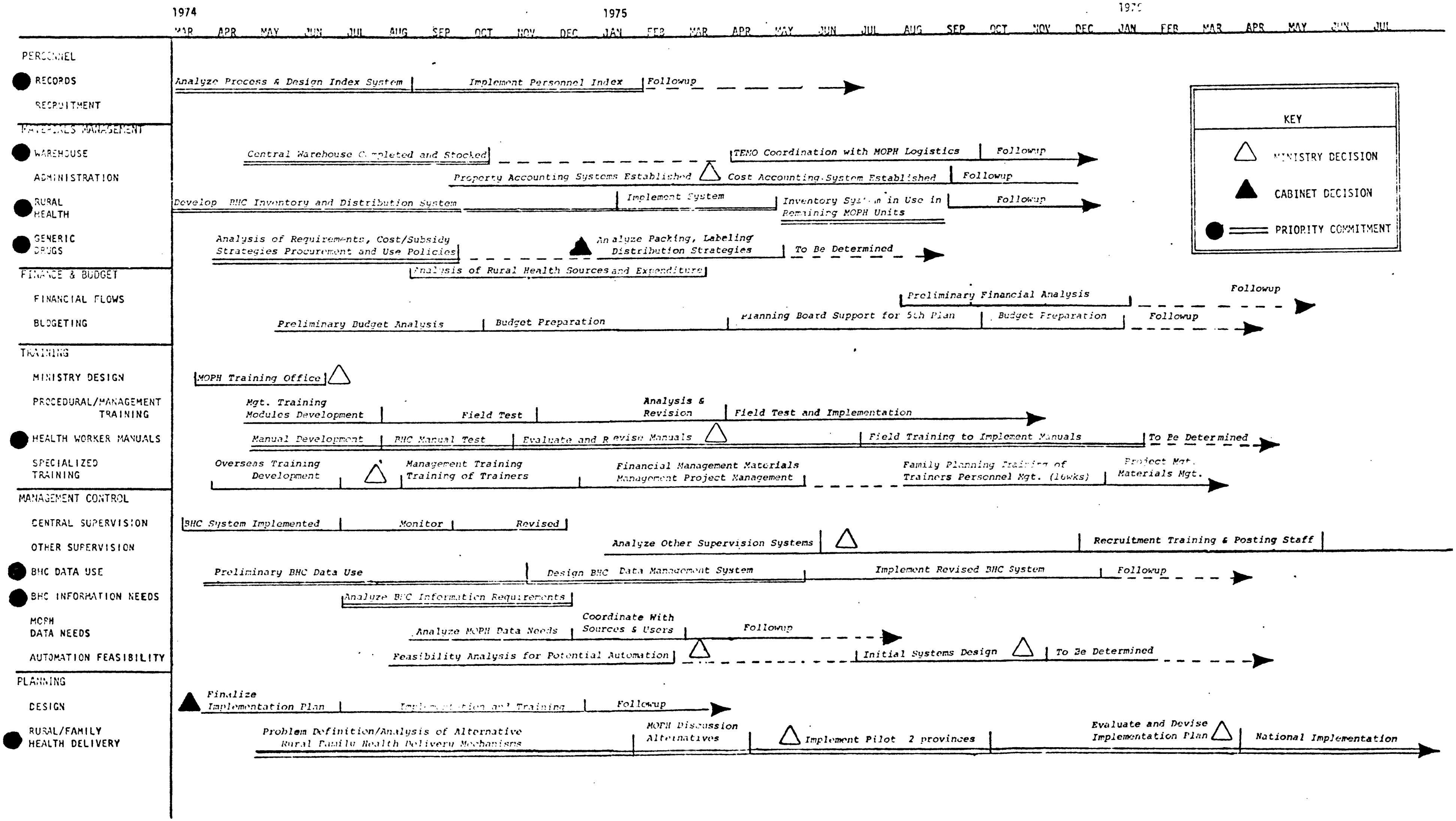
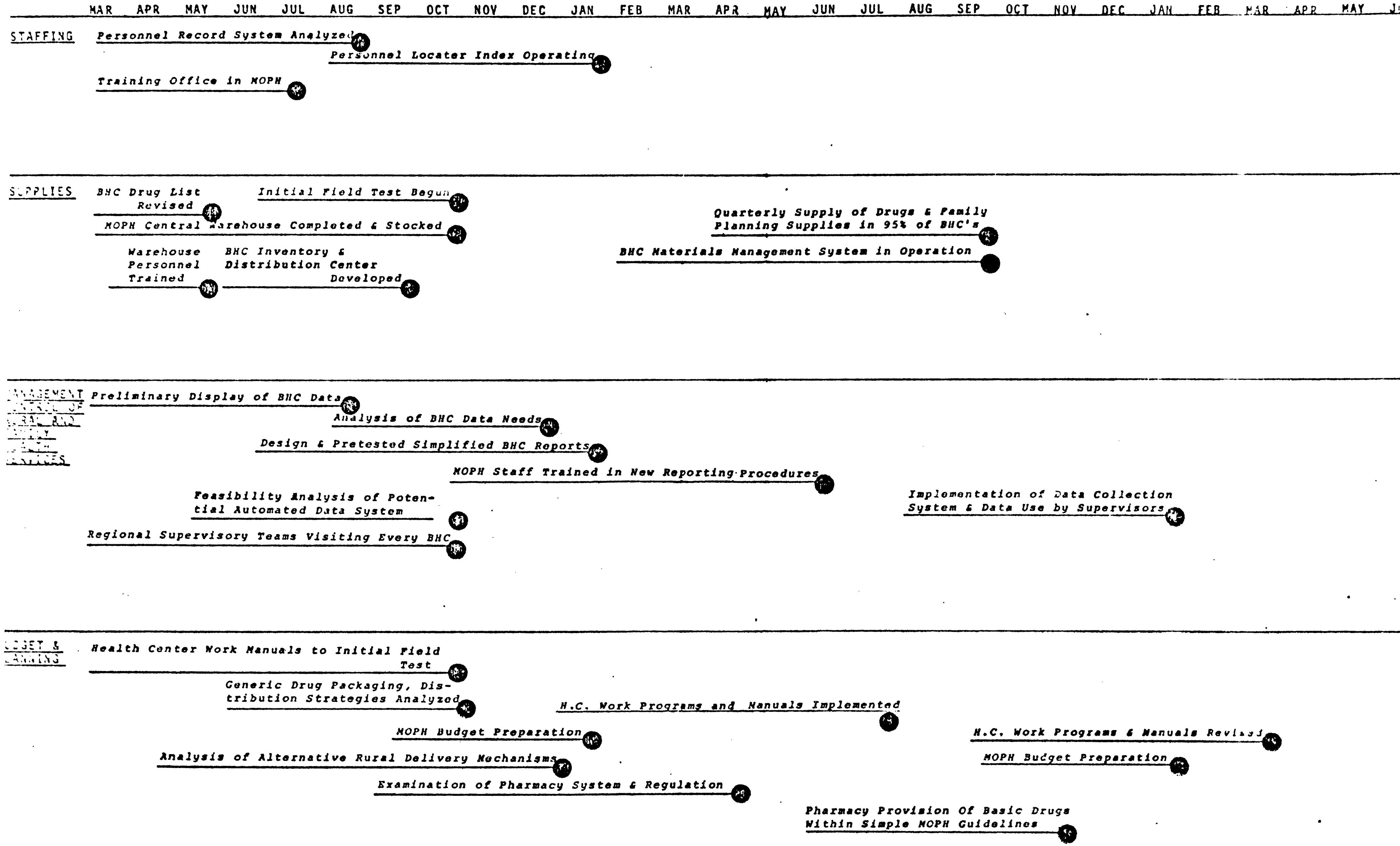


FIGURE 5.2

MANAGEMENT FOR RURAL & FAMILY HEALTH SERVICES

ANTICIPATED INITIAL WORK PLAN OUTPUTS [1]



[1] The symbol ——● implies an end point or action whereby the output is anticipated to occur, subject to the sequence of decisions & actions assumed feasible

probable, of course, that changing conditions, problems and opportunities will require adaptation of the timetable and activities required to move toward the desired outputs of staff and services, effectively planned and managed, for rural and family health improvement.

5.2 WORK PLAN CHARTS

See Figures 5.1 and 5.2, attached.

6. MONITORING SYSTEM

March 74

To maintain effective communications regarding project activity, the following monitoring system is envisioned:

a) Monthly Meetings: to be held in the Planning Board Conference Room, MOPH, with the Minister, the AID/PHA program officer, and other appropriate MOPH and International Agency Staff.

b) Semi-Annual Reports To summarize the activities, progress, plans, opportunities and problems posed by the MOPH Management Initiative.

At these brief meetings, the Team will review current programs and seek consultation and direction. The notes and actions indicated by the participants will be documented in writing.

APPENDICES

Appendix 1.1

GMD DRUG LIST FOR BHC's (ONE YEAR ALLOWANCE)

Medicine	Units	Maximum Allowance
Tab. Aspirin		10,000 Tab.
Tab. Aspicaf		3,000 Tab.
Tab. Ephedrine		500 Tab.
Tab. Novolax		3,000 Tab.
Tab. P.A.S.		9,000 Tab.
Tab. I.N.H.		6,000 Tab.
Tab. Sodament		9,000 Tab.
Tab. Vitamin B1	100 mg	3,000 Tab.
Tab. Vitamin B Complex		6,000 Tab.
Tab. Vitamin C	500 mg	3,000 Tab.
Tab. Vitamin B6		1,500 Tab.
Tab. Vitamin K		1,500 Tab.
Tab. Vitamin B2		1,500 Tab.
Tab. Vipet		11,500 Tab.
Tab. Aminophylline		1,500 Tab.
Tab. Bellabital		3,000 Tab.
Tab. Ant Acid		3,000 Tab.
Tab. Asphecod		6,000 Tab.
Tab. Sulphaguanadine		3,000 Tab.
Tab. Sedenal	0.06	3,000 Tab.
Tab. Sedenal	0.03	1,500 Tab.

Medicine	Units	Maximum Allowance
Tab. Terpicod		3,000 Tab.
Tincture Iodine		10 lit.
Amp. Penicillin	2 mil	30 Amp.
Amp. Penicillin	4 lakh.	60 Amp.
Cap. Tetracycline	250 mg.	250 Cap.
Cap. Tetracycline	50 mg.	500 Cap.
Gas Malmal	100 met	100 meters
Cotton Hydrophyl		10 rolls
Leucoplaster		5 rolls
Alcohol	80%	20 liters
Gas Bandage		10 Packs
Paraffine		1 Gallon
Rivanol Powder		50 Gm
Mercurochrome		20 Gm
Kalium Permanganate		500 gm
Chlor-Tetracycline eye oint.		250 tubes
Dist. Water		[illegible]50 Amp.
Amp. Atropine-Sulphate		50 Amp.
Amp. Coramine		50 Amp.
Amp. Baralgine		250 Amp.
Amp. Camphre		250 Amp.
Amp. Novocaine		250 Amp.
Amp. Adrenaline		50 Amp.
Amp. Gynergen		25 Amp.
Amp. Antistine		150 Amp.

Medicine	Units	Maximum Allowance
Amp. Glucose	10%	100 Amp.
Amp. Serum Physiologic		500 Amp.
Cat-Gut		50 Packs
Wrapping Paper		10 Kg.
Needles		5 Doz.
Syringe		6 Packs
Dittol		1 Gallon
Amp. Streptomycin	1 gm	50 Vials
Pomade Sulpnamide	10%	5 Kg.
Pomade Ichthyol	5%	3 Kg.
Amp. Prostigmine		10 Amp.

Appendix 1.2

UNICEF DRUG LIST FOR BHC's (ONE YEAR ALLOWANCE)

Medicine	Units	Maximum Allowance
Aneurin	Tablets	1,000
Ascorbic Acide (Vit. C)	Tablets	10,000
Calcium Lactate	Tablets	10,000
Camoquin	Tablets	3,000
Daraprim	Tablets	1,000
Ergometrine	Tablets	100
Ferrous Sulphate	Tablets	10,000
Todochlorhydroxgrin	Tablets	6,000
Isoniazid with Thiacetazone	Tablets	1,000
Piperazine	Tablets	3,000
Sulphathiazol	Tablets	8,000
Triasyn B	Tablets	10,000
Triple Sulphonamide	Tablets	7,000
Tetracycline Eye Oint.	Tubes	150
Vitamin A/D	Capsules	10,000
Ammoniated Mercury Ointment	Jars @ 1 lb.	3
Ferric Ammonium Citrate	Bottles/Jars @ 500 gr.	2
Sulfadiazine Powder	Bottles @ 500 gr.	1
Zinc Oxide Ointment	Jars @ 450 gr.	4

Medicine	Units	Maximum Allowance
Genticen Violet	gr.	25
DDT	Lb.	25
Soap	Bars	10
BCG	Ampules	50
Distilled Water	Ampules	100
Penicillin in Oil	Ampules	100
Penicillin Crystal	Ampules	100

Appendix 1.3

PROPOSED LIST OF DRUGS AND VACCINES

FOR BASIC HEALTH SERVICES

(WE SUGGEST THIS AS A LIST TO BE ORDERED FROM

AND TO BE TAILORED TO MATCH RESOURCES AT EACH BASIC

HEALTH CENTER)

Medicine	Units	Estimated[1] Annual Need (For 5 Pilot BHCs)	Cost (Dollars)[2]
Aminophylline	250 mg Tablets	2,500	10
Aspirin	300 mg Tablets	500,000	300
Atropine Sulfate	0.3 mg Tablets	200,000	180
Benzyl Benzoate	1 Ounce Lotion	1,000	65
Chloramphenical	250 mg Tablets	40,000	342
Chloroquine	150 mg Tablets	10,000	62
Chloroquine	100 mg Tablets	5,000	48
Colloidal Silver	Kilogram-Bulk[3]	1	100
Diphenhydramine	25 mg Tablets	2,500	9
Epinephrine	Ampule	50	17
Family Planning (Progesterone-Estrogen Tablets)		To be provided by USAID	
Ferrous Sulfate	300 mg Tablets	100,000	420
Folic Acid	5 mg Tablets	150,000	375
Glucose-Electrolyte[4] Oral Powder (for solution)	POWDER PACKETS	150,000	4,000
INH/Thiacetazone	300 mg/100 mg Tablets	To be provided by separate UNICEF Progra	

Medicine	Units	Estimated Annual Need [1]	Cost (Dollars) [2]
Iodine	Kilogram-Bulk[3]	2	17
Iron-Dextran	10 cc Vials	300	930
Kaolin	Kilogram-Bulk[3]	25	12
Lidocaine	2 cc Ampules	1,000	50
Magnesium Hydroxide	Kilogram-Bulk[3]	1	1
Methyl Ergometrine	0.2 mg Tablets	20,000	91
Methyl Ergometrine	Vials	1,000	60
Penicillin Procaine (Aluminum Monostearate stearate)	3 Mega-Unit Vial	4,000	1,800
Phenobarbital	30 mg Tablets	10,000	15
Phenylephrine	1/4%, 1/2% 1/2 oz. Bottles	2,500	750
Piperazine	250 mg Tablets	50,000	67
Poly Vitamins	Tablets	150,000	3,375
Primaquine	15 mg Tablets	10,000	44
Primaquine	7.5 mg Tablets	5,000	13
Pyrimethamine	25 mg Tablets	6,000	17
Ringer-Lactate I.V. Solution Plus Potassium[5]	1 Liter	To be provided by Preventive Medicine	
Sodium Bicarbonate	1 Gram Tablet	200,000	170
Streptomycin	1 Gram Vial	300	21
Terpin Hydrate	Kilogram-Bulk[3]	5	11
Tetracycline	250 mg Tablets	50,000	525
Tetracycline Eye Oint.	3.5 Gram Tube	10,500	3,000
Triple Sulfa	500 mg Tablets	150,000	428

Medicine	Units	Estimated Annual Need[1]	Cost (Dollars)[2]
Vitamin A + D	Combined Capsules	50,000	78
Whitfield's Ointment	1 Ounce Tubes	100	15
Zinc Oxide Ointment	1 Lb. Jar	15	2
	Approximate Total		$15,000

Vaccines[6]

Tetanus Toxoid	250 20-Dose Vials
BCG	Separate program
Smallpox	Separate program

Footnotes

1. Based on 5 pilot BHCs serving 50,000 people total who come regularly for care of common illnesses.

2. Costs based on generic prices, USA & UNICEF sources; costs may vary somewhat with source and time.

3. Items which need to be made into suspension ought to be bulk-shipped to be made up locally. This may not be feasible, however.

4. Glucose-electrolyte powder sealed up in plastic packets to be made to one liter solution at BHC (plastic pack may be designed to hold one liter)

Approximate composition	Per Packet
Sodium chloride	3.0 grams
Sodium bicarbonate	2.5 grams
Potassium chloride	1.5 grams
Glucose (dextrose)	25.0 grams

May be used ad-libitum for all diarrheas plus maintenance therapy especially in children.

5. Ringer-Lactate I.V. Solution plus 0.75 Gram Potassium Chloride per liter provides a single rehydrating fluid for all diarrhea and other instances of shock. The potassium chloride should be added before sterilization. UNICEF may be asked to supply some 20,000 empty bottles in 1974 at original approximate cost of $10-20,000 with shipping.

6. Situation not yet ready for other vaccines (such as DPT, Measles, Polio)

APPENDIX 1.4
MSH List of Essential BHC Drugs

MSH DRUG LIST
ALPHABETICAL INDEX

DRUG	UNITS	DRUG_ID	CATEGORY
AMINOPHYLLINE	AMPULES	25010	CARDIOVASCULAR,STIMU
ASPIRIN	300MG	7010	ANALG,NONNARC,ANTPYR
BENZYL_BENZOATE	LOTION_OZ	57051	ANTISEPTICS
CHLORAMPHENICOL	250MG	58040	ANTIBACTERIAL
CHLOROQUI_PRIMAQUINE	TABS_ADULT	61016	ANTI_MALARIAL
	TABS_CHILD	61015	ANTI_MALARIAL
COLLOIDAL_SILVER	KILOGRAM	57080	ANTISEPTICS
DIAMINO_DIPHENYL_SUL	25MG	60010	ANTI_LEPROSY
EPHINEPHERINE_IN_OIL	AMPULE	19021	SYMPATHOMIMETIC
EPINEPHRINE	AMPULES	19020	SYMPATHOMIMETIC
FERROUS_SALTS	300MG	29020	HEMATOPOETIC
FOLIC_ACID	1MG	29030	HEMATOPOETIC
GLUCOSE_ELECTRO_ORAL	PACKETS	33050	ELCTRLYT&WTR_RPLACMT
HYDROCORTISONE_OINT	5MG_TUBES	54061	GLUCO_CORTICOIDS
INH_THIACETAZONE	TABS_ADULT	59065	ANTI_TUBERCULOSIS
IODINE	KILOGRAM	57180	ANTISEPTICS
IRON_DEXTRAN	10CC_VIALS	29035	HEMATOPOETIC
KAOLIN	KILOGRAMS	45040	ANTI_DIARRHEAL
LIDOCAINE	AMPULE	8020	ANAESTHETICS,LOCAL
MAGNESIUM_HYDROXIDE	KILOGRAMS	41080	ANTACID
METHYL_ERGOMETRINE	0.2MG	69021	OXYTOCIC
METRONIDAZOLE	250MG	63040	AMEBICIDE
MORPHINE	AMPULE	6040	ANALGESTIC,NARCOTIC
PEN_PRO_AL_MONOSTERA	VIALS_3MU	58185	ANTIBACTERIAL
PHENOBARBITAL	30MG	2060	HYPNOTICS
PHENYLEPHRINE	OUNCEFLACO	19060	SYMPATHOMIMETIC
PIPERAZINE	250MG	64050	ANTI_HELMINTHIC
POLY_VITAMINS	TABLETS	46120	VITAMINS
PROGESTERONE_ESTROGEN	TABLETS	48060	PROGESTERONES
RINGERS_LACTATE_SOL	LITERS	33090	ELCTRLYT&WTR_RPLACMT
SODIUM_BICARBONATE_P	KILOGRAM	33110	ELCTRLYT&WTR_RPLACMT
STIBOPHEN	AMPULES	62050	ANTI_LEISHMANIAL
TERPIN_HYDRATE	KILOGRAM	39060	EXPECTORANT
TETRACAINE_BULK	KILOGRAMS	8050	ANAESTHETICS,LOCAL
TETRACHLORETHYLENE	1MLCAPS	64090	ANTI_HELMINTHIC
TETRACYCLINE	OINTMENT	58313	ANTIBACTERIAL
	250MGCAP	58310	ANTIBACTERIAL
TRISULFAPYRIMIDINE	500MG	58330	ANTIBACTERIAL
VIT_A_(RETINOL)	AMPULE	46010	VITAMINS
WHITFIELDS_OINTMENT	TUBES_1OZ	65050	ANTI_FUNGAL

APPENDIX 2.1

MONTHLY REPORT FORM FROM BASIC HEALTH CENTERS

Ministry of Public Health
Department of Statistics
and Human Resources

PART ONE: IDENTIFICATION Report of Health Establishments

Name of Hospital Health Center Secondary Center	Local Government	Province	Month and Year of Report Month Year

PART TWO: NO. OF VACCINATIONS

Age Group	B.C.G.	Smallpox	Colera	Typhoid	Others	D.P.T. First	D.P.T. Second	D.P.T. Third
Less than one year								
1 - 4 years								
5 - 14 years								
15 years and up								
Age Unkhown								
Total								

PART THREE: TUBERCULOSIS REPORT

Type of Incident	No. of incidents in the beginning of the month	New Cases	Old Cases	Deaths	Dropouts	No. of incidents at the end of the month
Proven						
Suspected						
Total						

PART FOUR: OTHER ACTIVITIES MCH CLINIC

Outpatient		Visits	Visitors to child and mother care center	
Age Dist.		Number	Type of visit	Number New Total
Less than one year			Less than one year	
1 - 4 years			1 - 4 years	
5 - 14 years			Before birth	
15 years and up	Woman		After Birth	
	Man		BIRTHS Home	
Age Unknown			BIRTHS At the Center	
Total			BIRTHS Total	

Total No. of Home Visits During the Month		
Lab Check Ups for Diseases		
MALARIA Passive Case Detection	TUBERCULOSIS SPUTUM +	TUBERCULOSIS SPUTUM -

REMARKS:

Date and Signature:

Basic Source of General Service Statistics - One sent from each BHC monthly to MOPH Statistics & Manpower Div.

Department of Statistics and Health Resources Publication

APPENDIX 2.2

D A I L Y   W O R K   S H E E T   BHC's DAILY WORK SUMMARY SHEET

........................:ANM/AN   13...:Year   ....:Month   ....:Province   ....:Health Center/Sub Centre

REMARKS	VACCINATION & IMMUNIZATION													TB PATIENTS TREATED			SPECIMEN COLLECTED			POLY-CLINIC ATTENDANCE						DATE
	Other *		DPT			Smallpox				BCG				Home	Clinic					Age-group						
			3rd.	2nd.	1st.	15+	5-14	1-4	-1	15+	5-14	1-4	-1		R	1st.	U	SP	BS	NK	15+ F	15+ M	5-14	1-4	-1	
																										1
																										2
																										3
																										4
																										5
																										6
																										7
																										8
																										9
																										10
																										11
																										12
																										13
																										14
																										15
																										16
																										17
																										18
																										19
																										20
																										21
																										22
																										23
																										24
																										25
																										26
																										27
																										28
																										29
																										30
																										31
																										32
																										Total
																										Grand Total

*) Specify.   R = Repeat visit   U = Urine test   SP = Sputum   BS = Blood Smear   NK = Age not known   F = Female   M = Male

Page ..

APPENDIX 2.3

DAILY WORK SHEET

..........................:ANM/AN 13...:Year ....:Month ....:Province ....:Health Centre/Sub Centre

NAME OF VILLAGES VISITED	OTHER		CHILD HEALTH						MATERNITY									DATE
	Home Visits*		1-4 Years			Under 1 Year			Post Natal			Deliveries		Ante Natal				
			Home	Clinic		Home	Clinic		Home	Clinic				Home	Clinic			
				Repeat	1st.		Repeat	1st.		Repeat	1st.	Home	Clinic		Repeat	1st.		
																		1
																		2
																		3
																		4
																		5
																		6
																		7
																		8
																		9
																		10
																		11
																		12
																		13
																		14
																		15
																		16
																		17
																		18
																		19
																		20
																		21
																		22
																		23
																		24
																		25
																		26
																		27
																		28
																		29
																		30
																		31
																		32
																		Total
																		Grand Total

*) Specify

APPENDIX 2.4

SEE OVER

BHC :

(ONE CARD FILLED OUT FOR EACH MCH MOTHER, Normally on first visit)

Afghanistan: Mother's Card, FRONT

Province	Health Centre/ sub centre	Date of 1st. visit	Address of mother	MOTHER'S CARD :NO.
: Occu- pation	: Name of husband	:Age	:Name	Previous cards no
:Number of rooms :Water source	: Over 15 years	: Below 15 years	: Household size, total	

PREVIOUS PREGNANCIES					HISTORY OF DISEASES	FIRST MEDICAL EXAMINATIO
Nature of pregnancy, delivery and puerperium	Age **	Sex	Result *	No.	☐ None	(General condition, breas and nipples, glands, hea lungs, liver, spleen, bony deformaties etc.)
				1	☐ TB	
				2	☐ Heart	
				3	☐ Gynae/abd.op.	
				4	☐ Diabetes	
				5	☐ ______	
				6	☐ ______	
				7	☐ ______	☐ Normal
				8	☐ ______	☐ Abnormal(spcf
					☐ ______	:VDR
					☐ ______	:Result :Dat
					☐ ______	

* Liveborn
Stillborn
Abortion

** Age of living child.
If dead, draw a ring around age of infant at death.

: Others (spcf)	☐ Heamorrhage	☐ Vag. discharge	______ :First day last LMP	: PRESENT PREGNANCY
	☐ Headache	☐ Scanty urine	______ :Weeks of gestation	
	☐ Oedema	☐ Vomiting	______ :Exp. day of delivery	

PROGRESS OF PRESENT PREGNANCY

REMARKS	Oedema	Foetal heart	Free/engaged	Presentation	Fundal height	Hb %	Urine	Weight	Blood pressure	At home(H) or at Clinic(C)	Date
:FOOD COUPON											
:DATE											

APPENDIX 2.4

Afghanistan: Mother's Card, BACK

: Discharged date & hour	: Admitted date & hour	☐ Health Centre	☐ Referred to Hospital	☐ Home	DELIVERY Place of
: Time called date & hour	: Designation				: Birth attendant name
: General condition	: State of membranes	☐ Contraction	☐ Show		: Condition of mother on arrival of attendant
					: Progress of labor
		: Other (spcf)	☐ Normal		: Type of delivery
☐ Incomplete	☐ Complete	☐ Assisted	☐ Spontaneous		: Delivery of placenta and membranes
: Other (spcf)	☐ Repair	☐ Tear	☐ Heamorrhage	☐ None	: Complications to mother

Condition at birth (asphyxia, injury, anomalies etc.)	Abortion	Birth weight	Still born	Live born	Sex	Delivery date & hour	Result of delivery
							1st. child
							2nd. child

If dead, cause of death	After 28 days		After 7 days		Survival of liveborn
	dead	alive	dead	alive	
					1st. child
					2nd. child

POSTNATAL EXAMINATION	Date

2

POSTNATAL CARE Observations and advise	Date

1

3 : Cause of death ☐ Dead ☐ Not known ☐ Alive : Survival of mother 6 weeks after delivery

4 : Other (spcf) ☐ Sterilization ☐ Pill ☐ IUCD ☐ Yes ☐ No : Accepted ☐ Yes ☐ No : Familyplanning advise given

SEE OVER

APPENDIX 2.5

Afghanistan: Child's Card, FRONT

(ONE CARD FILLED OUT FOR EACH MCH CHILD, normally on first visit)

Province	Health Centre/ sub centre	Date of 1st. visit	Adress of child	CHILD'S CARD :NO.
:Birth weight	:Date of birth	M F :Sex	:Child's name	:Mother's card no.
:Father's occupation	:Father's Name	:Mother's name and age		
:Number of rooms :Water source	:Over 15 years	:Below 15 years	:Household size, total	

Immunizations

Date	Date	Date	Date	Vaccinations
				B C G
				Smallpox
				Diphtheria
				Tetanus
				Wooping cough
				Typhoid
				Poliomyelitis

Development

Give age when each started

- ____ ☐ 1st. tooth
- ____ ☐ Sitting alone
- ____ ☐ Standing "
- ____ ☐ First word
- ____ ☐ Walking alone

:Remarks

IF/Parasitic diseases

Age Yes(✓)

- ____ ☐ Smallpox
- ____ ☐ Measles
- ____ ☐ Wooping cough
- ____ ☐ Chickenpox
- ____ ☐ Typhoid fever
- ____ ☐ Tuberculosis
- ____ ☐ Intestinal parasites
- ____ ☐ Poliomyelitis
- ____ ☐ ____
- ____ ☐ ____

N U T R I T I O N

..........:Additional food at what age ....:Breast fed up to age

Other	Fruit	Other	Green	Pulses	Meat	Egg	Milk	Cereal	Type of food
									Given at age

:(including child's history of health) FIRST MEDICAL EXAMINATION

	Laboratory	
	Result	Test

:Date
:Weight
:Height
Head circumf.
:Arm circumf.

:Any signs of
Yes(✓)

- ☐ Xerosis
- ☐ Glossitis
- ☐ Angular stomats.
- ☐ Keratomalacia
- ☐ Bitot's spots
- ☐ Oedema
- ☐ Anaemia
- ☐ ____
- ☐ ____

:FOOD COUPON

:DATE

:Date and signature

Afghanistan: Child's Card, BACK

(C = at clinic, H = at home) F O L L O W U P								
Signature	Progress, findings, diagnosis & advise	Laboratory Result	Test	Height	Weight	Age	C or H	Date

Record ends	Alive ☐	Reason (e.g. entered school)
Date	Dead ☐	Cause of death

APPENDIX 2.6

راجستر اطفال (کلینک حمایهٔ مادر وطفل)

WFP CHILDRENS REGISTER (MCH)

ملاحظات REMARKS	سن AGE		جنس SEX		قریه DISTRICT	اسم پدر FATHER'S NAME	اسم NAME	نمبر کارت CARD No	تاریخ راجستر شدن DATE OF REGISTRATION
	ساله ٥-١ 5-1	ساله ١-٠	مونث F	مذکر M					

دلیل : ختم نمودن کارت ازقبیل داخل شدن طفل به مکتب یا وفات طفل با تاریخ ان تذکر داده شود

REASON should be given when a card is no longer active for example entrance of child in school or mortality.

(FORM USED TO REGISTER CHILDREN For WFP Commodities)

APPENDIX 2.7

MOTHER'S REGISTER (For WFP)

راجستر مادر

ملاحظات Remarks	REASON FOR REGISTRATION راجستر شده به منظور: بعد از ولادت POST-NATAL	زمان ولادت DURING DELIVERY	قبل از ولادت PRE-NATAL	قریه DISTRICT	اسم پدر FATHER'S NAME	اسم NAME	نمبر راجستر REGISTER NUMBER	تاریخ DATE

APPENDIX 3

PROCUREMENT OF LOWER-COST, QUALITY DRUGS: AN ANALYSIS WITH RECOMMENDATIONS FOR THE MINISTRY OF PUBLIC HEALTH, GOVERNMENT OF AFGHANISTAN

Management Sciences for Health

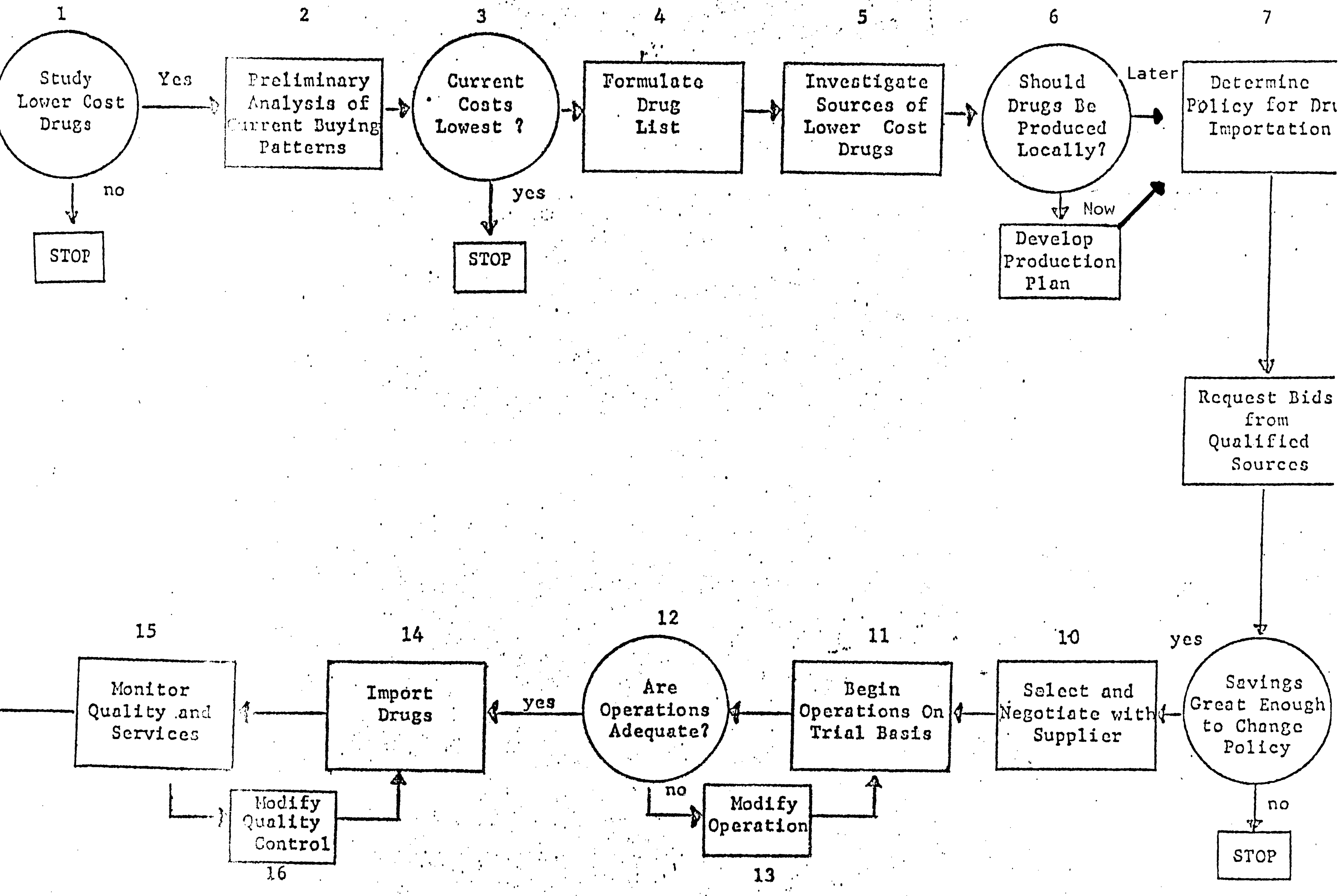
March 10, 1974

INDEX

A. INTRODUCTION

This report will present some of the strategies by which Afghanistan can provide quality drugs relevant to the needs of the people at the lowest possible prices.

The Ministry of Public Health (MOPH), Government of Afghanistan (GOA), has recognized that much foreign exchange was being spent annually on medicines, particularly on proprietary (brand-name) drugs (one unofficial estimate is $5 million per year), yet relevant medicines were not always available, especially in rural areas, and were often costly for the people. MSH was asked to look into the managerial strategies involved in establishing a national drug policy, especially with regard to the purchase of generic drugs. Late in 1973, a series of steps required was outlined (see the attached flow chart). At present, the preliminary analysis of current buying patterns is nearly completed (steps 2 - 3), and is presented, in part, in this report. The results indicate that buying drugs actually needed and in the proper volumes may provide substantial savings in addition to those gained from buying generic drugs only. A generic drug list has been drawn up by officers of the General Medical Depot (GMD) and professors of medicine and pharmacology (step 4). We are, with the MOPH, exploring sources of lower-cost drugs (step 5) and preliminary investigations into the feasibility and extent of in-country production of drugs has begun (step 6). We are now at step 7, where the MOPH is in position to make the important policy decisions.



1
Study Lower Cost Drugs
Yes
no
STOP
2
Preliminary Analysis of Current Buying Patterns
3
Current Costs Lowest ?
yes
STOP
4
Formulate Drug List
5
Investigate Sources of Lower Cost Drugs
6
Should Drugs Be Produced Locally?
Later
Now
Develop Production Plan
7
Determine Policy for Dru Importation
Request Bids from Qualified Sources
Savings Great Enough to Change Policy
yes
no
STOP
10
Select and Negotiate with Supplier
11
Begin Operations On Trial Basis
12
Are Operations Adequate?
no
13
Modify Operation
yes
14
Import Drugs
15
Monitor Quality and Services
16
Modify Quality Control

NOTES TO THE CHART

1. Study Lower Cost Drugs - Is there an indication that drugs are not currently being bought at the most advantageous rate? A decision must be made at this point whether or not to undertake a study of alternate methods of obtaining drugs.

   Yes - Begin step #2
   No - Stop

2. Preliminary Analysis of Current Buying Patterns - What are the present methods of obtaining drugs? Who supplies them? What quantities are being bought? What is the price being paid for various drugs?

3. Current Cost Lowest - Is as preliminary analysis (#2) indicate that drugs are currently being obtained in the most economical fashion? A decision must be made at this point whether or not to seek a new procedure for ordering drugs.

4. Yes - Continue to step #4
   No - Stop

4. Review drug needs - Which drugs are most commonly used and therefore result in greatest savings if ordered as generic? A review of the most useful drugs should be undertaken at this point and a list of essential drugs produced.

5. Investigate sources of lower cost drugs - Who are reliable suppliers of lower cost drugs? Drug producers should be contacted to determine their willingness to provide generic drugs to Afghanistan. At the same time companies should be analyzed for reliability and quality and a screening should be carried out to determine which companies are to be approved for bidding.

6. Drug production in Afghanistan - Is it feasible and economic to produce generics in Afghanistan? Decision.

   Yes - Develop production plan
   No - Rely on importation (Step #7)

7. Determine Policy for Drug Importation - What regulations and licensing procedures must be followed by importers?

8. Request bids from Approved Sources - A list of drugs required, quantities and delivery schedules will be sent to qualified bidders.

9. Are Savings of Generic Procurements Great Enough to Change Policy? Does the analysis of the bids received indicate that substantial savings are to be gained by generic production? Decision:

Yes - Begin selection and negotiate (#10)
No - Stop

10. <u>Select and Negotiate with Supplier</u> - Which suppliers will provide most savings and best service. Select best supplier(s) and being negotiation. Decision:

Which supplier to select?

11. <u>Begin Pilot Operations</u> - Start importation of drugs on trial basis.

12. <u>Are Operations Adequate</u> - Does an evaluation of pilot operation indicate satisfactory service?

Yes - Continue existing operations on full scale (#14)
No - Change operations and select new supplier if necessary (#13)

13. <u>Modify Operations</u> - If operations are not adequate, what new procedures will bring improvement.

14. <u>Import drugs</u> - Establish long term procedures for importation of generic drugs.

15. <u>Monitor Quality and Services</u> - Set up methods for evaluating quality of drugs and services provided by contractor? <u>Decision</u>:

Is quality adequate -

Yes - Continue operations
No - Modify operation (#16)

16. <u>What modifications are necessary to insure satisfaction</u> - Contractor must modify his operations to overcome any problems discovered during evaluation. If improvement is not made by contractor a new source of supply will be found.

B. GOALS AND STRATEGIES

1. The goals of a rational drug policy are to:

a) Define those drugs relevant to the people's needs and in amounts needed;

b) Insure availability of quality drugs at lowest possible prices;

c) Increase the self sufficiency of Afghanistan in obtaining medicines.

2. The following are some possible policies to meet these goals:

a) BUY GENERIC DRUGS WHENEVER POSSIBLE

b) BUY DRUGS ON A BID SYSTEM

A bid system ought to be sufficiently flexible to allow for on-the-spot purchases as well as long-term contracts. Quality control is a necessary component of a bid system.

c) LIMIT PURCHASES TO DRUGS ACTUALLY NEEDED AND IN VOLUMES WHICH CORRESPOND TO AVAILABLE SERVICES

Priority would be given to the purchase of curative, preventive and life saving drugs, over the purchase of drugs that provide mild symptomatic effect, that are only minimally effective, or are clearly used as placebos.

d) PRODUCE MANY OF THE COMMONLY USED DRUGS IN AFGHANISTAN

3. Strategies to explore for implementation of the policies:

a) Possible ways to import low-cost quality drugs:

i) ALL DRUG IMPORTATIONS ARE CONTROLLED BY THE MINISTRY OF PUBLIC HEALTH

This would require either a cost-reimbursable arrangement with UNICEF (it is uncertain that this Agency would be willing to supply a country's

entire formulary); <u>or</u> a contract with an outside expert broker who would be hired on commission to seek out and purchase the lowest cost drugs on behalf of the GOA; <u>or</u> a major expansion of the GMD functions and staff to accomplish the same effect.

ii) CONTINUE PRIVATE SECTOR IMPORTATION OF MOST DRUGS, BUT UNDER MORE STRINGENT REGULATIONS BY GOA

Drug imports would be limited to those on a new generic formulary and the prices paid would become a matter of public record.

iii) THE MOPH TO CONCENTRATE ON SUPPLYING RURAL DRUG NEEDS THROUGH AN EXPANDED BASIC HEALTH CENTER (BHC) SYSTEM

This option essentially expands on the present GMD function. Competition with a co-existing private sector is inevitable; due to the advertising efforts of major drug companies, the lower cost of BHC drugs may not necessarily attract patients to the BHCs.

b) <u>Possible sources of funds for GOA implementation of a new drug policy</u>:

We recognize that a reduction in costs may be balanced by expansion of services,requiring additional funds.

i) UNICEF FUNDS

Monies may be available to supply a component of Basic Health Center needs.

ii) AFGHAN PEOPLE

The Afghan people may desire to pay a portion of the costs of generic drugs imported or produced by the GOA and distributed through the BHCs. Medicines on which even a small charge is levied are more likely to be used and valued.

c) Possibility of major generic drug production by GOA:

In-country production will provide a local source of employment, a capability to control directly the quality of drugs, and increased national self-sufficiency. At the same time that new strategies for importation are explored studies of the costs and benefits of national production should also be studied. Important issues include:

i) Capital and Production Costs: What will it cost to build and equip a production facility in Afghanistan? What will be the manpower and overhead costs? Will the total cost of producing drugs in Afghanistan be less than continued importation of finished drugs?

ii) Investment and Operational Control: What sources of funding will be used in the capital investment for in-country production? Should the facility be the sole ownership of GOA, or a joint government venture with an established producer, or a private enterprise? Regardless of the ownership, what controls will be applied to minimize the cost of production and to supply drugs at the lowest cost to the public?

iii) Drugs to be Produced: Which drugs are most needed and used? Of these, which drugs, because of the complexity of their production, will have to continue to be imported? Will drugs be produced only for the public sector or for the entire national market? What are the requirements for quality control?

iv) Manpower Needs: What personnel in Afghanistan currently have training and capability in drug production and quality control?

What additional trained personnel will be necessary in order to establish production? What is the most effective way to train additional Afghans to carry out an essential role in in-country production?

4. A Possible Mix of Strategies:

To meet the three goals outlined in Section B of this report, an initial mixture of strategies might include:

a) Use of UNICEF and GMD funds to provide an expanded BHC formulary based on known epidemiology and an improved reporting system from the BHCs;

b) If analysis confirms an unacceptable loss of foreign exchange, government regulation of current private-sector drug imports may be considered with regard to a restricted national formulary of generic drugs, the amounts of drugs ordered, and prices paid;

c) Vigorous investigation, with assistance from expert consultants, of steps to begin in-country production; The Hoechst Co. is an important local resource;

d) Acquisition of managerial skills by management trainees could proceed in parallel with these efforts.

e) Any new strategy should be started carefully, after sufficient preparation; the education of physicians, pharmacists, the health workers, and the Afghan public will be necessary.

C. DRUG IMPORT POLICIES - A PRELIMINARY, COMPUTER-ASSISTED ANALYSIS

1. Summary

To assist the MOPH in selecting national strategies for procuring quality drugs at low cost we have begun an analysis of drug costs, sources, and the relevance of drugs purchased to actual need. Some of the results are presented here. The important conclusions from this preliminary analysis are:

a) The cheapest way to buy drugs commercially is on a generic basis, by bid.

b) The choice of drugs and their volumes are critical determinants of overall cost.

c) The costs of GMD purchases over the past four years have been quite low and current expenditures could supply an active BHC program.

2. Methodology

a) Four Separate Drug Lists Enter the Analysis

i) "GMD" -- The drug list from the General Medical Depot, which supplies government hospitals and rural health centers, and the records of actual purchases over the past four years were kindly supplied us by Dr. S. Weiss. This list is designated "GMD".

ii) "NNF" -- This list is the new generic drug list, not yet officially adopted. This was compiled by eminent Afghan physicians and pharmacologists in 1973 and is designated in this report and the computer printouts as "NNF".

iii) "BHC" -- This list is a prototype Basic Health Center drug list based on epidemiologic and demographic data already known. This is only a first

effort carried out by MSH, intended to demonstrate a method of estimating actual drug needs and requires considerable Afghanistan input in order to be relevant to Afghanistan. Hence we designate it "MSH".

iv) "<u>IMP</u>" -- The list of drugs imported by the private sector into Afghanistan is now being collected and will be analyzed shortly. This list will be called "IMP".

Each drug, by generic name, is given an identifying number based on its pharamcologic action and its alphabetical position within that category. Different preparations of a drug (i.e., oral, parenteral, topical) are given separate numbers. Computer printouts of these lists are attached.

b) <u>The volumes of drugs from each list were obtained as follows</u>:

i) "<u>GMD</u>" -- The actual total purchases over the past four years (1349 - 1352) divided by four, gave a figure of annual drugs purchased by the GMD.

ii) "NNF" -- Officials from the General Medical Depot gave us their tentative estimate of annual national needs of most of the drugs on the list.

iii) "BHC" -- Estimates of need of drugs on the prototype BHC drug list were computed based on the commonest illnesses, known demographic breakdown by sex and age, known rational courses of therapy and pegged to a hypothetical population of one million rural people utilizing the BHCs for total care. The details of this exercise are given in the Appendix.

iv) "<u>IMP</u>" -- The actual values of drug importations by the private sector: This data is pending.

Where not specified on the lists, the dose of the medicine in question was taken as the commonest used; ampoules were taken to provide single doses (i.e., used once only).

c) The possible costs of drugs were derived from several sources. All are exclusive of shipping costs and valid only for the year quoted.

i) "GMD-ACTUAL" -- GMD actual prices paid from 1349-1352 (averaged to give annual expenditure) is designated "GMD-ACTUAL."

ii) "UNI" -- UNICEF listed prices on a restricted number of items (1973) is designated "UNI".

iii) "IDE" -- Generic drug prices from a USA broker (1974) is designated "IDE".

iv) "ICN" -- Generic drug prices from a USA generic manufacturer (1974) is designated "ICN".

v) "PRO" -- Average proprietary USA wholesale (1974) drug prices on medicines otherwise available generically (e.g., "Serpasil" for reserpine) designated "PRO".

vi) "IMP" -- The actual costs of drugs imported by the private sector are now being obtained and is designated "IMP".

THIS COMPUTER ANALYSIS OF BIDS ON WHOLE OR PARTIAL LISTS CAN BE USED IN THE FUTURE FOR MANAGERIAL AND COST-ACCOUNTING PURPOSES WHENEVER ACTUAL BIDS ARE OBTAINED.

3. Results

a) Drug Lists

List	# of Drugs on List	Total # of Preparations	# of Preparations With Known Prices and % of Total
"GMD"	206	237	207 (87%)
"NNF"	422	486 (467 with an estimated need given)	321 (66%)
"BHC"	38	40	39 (98%)
"IMP"		Data Pending	

Comment: The 40 preparations on the prototype Basic Health Center drug list "BHC" are thought to cover 26 diseases or conditions which we estimate make up nearly 90% of problems seen at a typical Basic Health Center.

b) Source of Drugs Related to Costs

The prices of drugs from several sources were compared:

i) "GMD-ACTUAL" - Actual GMD purchase costs (principally from non-USA sources) (1349-1352)

ii) "UNI" - UNICEF listed prices, 1973

iii) "IDE" - USA generic broker's prices, 1974

iv) "ICN" - USA generic manufacturer's prices, 1974

v) "PRO" - USA proprietary prices for generic drugs, 1974

vi) "IMP" - Drugs imported by private sector to Afghanistan

If "GMD-ACTUAL" is used as a base for comparison of relative costs and assigned a number of 1.0, the relative costs from the various sources are:

"GMD-ACTUAL" is 1.0

"UNI" is 1.1 x "GMD-ACTUAL"

"IDE" is 2.4 x "GMD-ACTUAL"

"ICN" is 2.9 x "GMD-ACTUAL"

"PRO" is 8.1 x "GMD-ACTUAL"

"IMP" Data Pending

Comment: In the USA, buying unpatented (generic) drugs by a brand name costs, on the average, 3-4 times more (one extreme - "Serpasil" for reserpine costs 40 times as much!) But even on the new generic list 22% of the drugs are still under US patent, hence "proprietary". 10% of both the "GMD" and "BHC" list are under patent. Buying from a generic broker, who can buy from many sources and at the right time, is generally cheaper than buying from a large generic drug manufacturer. UNICEF - a non-profit broker for the drugs it buys is the cheapest source for many items; the GMD has paid generally equivalently low prices (although the quotations are several years old). The GMD imports probably less than 5% of Afghanistan's drugs. The rest is imported by private wholesalers. Judging from the current official National Formulary most of these imports are proprietary drugs; hence their relative costs are several times that of the GMD purchases.

c) Total Costs of the Several Lists

If the "NNF" list - the generic drug list - were purchased at USA generic broker prices, according to the volumes estimated for annual need by the officials of the GMD, the cost would be at least $11,500,000. Even at lowest possible prices

(UNICEF or GMD sources), the "NNF" list would still cost about $5,000,000. The GMD actual annual purchases (averaged over four years from the data available to us) came to $186,000. A prototype formulary for an active Basic Health Center system - the "BHC" list - with needs as developed in Appendix I - would, at USA generic broker prices, cost $457,000. At lowest prices, the cost would be about $200,000, or just about equivalent to the annual GMD expenditure.

d) Choice of Drugs in Relationship to Cost

Where resources are limited, thought needs to be given to the type as well as quantity of goods purchased. One way to see how resources are distributed on drugs is to rank the first ten drugs in order of cost as percentage of the total cost. The results by each list are as follows:

"NNF" Drug	% of Total Cost	"GMD" Drug	% of Total Cost	"BHC" Drug	% of Total Cost
Streptomycin	14%	Penicillin-Streptomycin	19%	Glucose-Electrolyte Oral for Diarrhea	17%
Vitamin B12 Ampule	13%	Penicillin Procaine	11%	Tetracycline Eye Ointment	11%
Cortisone Ointment	8%	Codeine	5%	Ringer's Lactate	11%
Penicillin Procaine	7%	Alcohols	5%	INH/Thiacetazone	10%
Chlortetracycline Capsules	5%	Sulfaguanidine	4%	Iron Dextran	8%
Chlortetracycline Eye Ointment 1 oz.	4%	Diphenylhydantoin Ampule	4%	Penicillin Procaine Aluminum Monostearate	8%
Chloramphenicol 2 oz. bottle	4%	Methadone	3%	Triplesulfa	5%
Vitamin C ampule	3%	Dihydrostreptomycin	2%	Phenylephrine	3%
Sulfaguanidine	3%	Isotonic Saline	2%	Piperazine	3%
Chlorpromazine 4 oz. bottle	2%	Isotonic Glucose	2%	Whitfield's Ointment	3%
	63%		57%		79%

Comment: The "NNF" list top ten has two drugs used largely as placebos (B12 and Vitamin C ampules); two proprietary tetracycline preparations (chlortetracycline), for which generic equivalents are available; two liquid preparations, more easily reconstituted locally; and one poorly absorbed drug shown not to be particularly effective in diarrhea (sulfaguanidine). The "GMD" list top ten reflects the government purchase of hospital and clinic basic needs (narcotics and alcohol for galenicals). Intravenous fluids and penicillins are among the many items which could be produced in Afghanistan. The "BHC" list top ten reflects attention to particularly common diseases -- diarrhea, conjunctivitis, tuberculosis, anemia, common infections (pneumonia, otitis, impetigo, etc.), upper respiratory illness, worms, and fungal skin disease.

The choice and volume of drugs ordered are critical determinants of cost. In order to implement a rational drug policy (set out in Section B of this report), strict priorities of drug buying must be established, one based on economics, patients' needs, and good standards of medical practice.

4. Addendum

With the kind cooperation of Dr. S. A. Weiss and his colleagues in the GMD and the Ministry of Commerce, we have begun the analysis of drugs imported into Afghanistan by private wholesalers and private manufacturers.

a) The total recorded foreign exchange expenditure for medicines was:

Millions of Dollars				
1347	1348	1349	1350	1973(U.S.)
$2.5	$3.3	$3.9	$5.0	$4.7

(NOTE: Afg. year 1347 overlaps Western year 1967)

b) We have made a preliminary analysis of approximately 15% of retail drugs imported by wholesalers in 1973. (A final analysis will be completed within the next month.) A.l drugs were bought by brand name. The following is a list of drug categories and the costs of each category as a percent of the total:

CATEGORY	% OF TOTAL COST	
Antibiotics (one ingredient)	23%	
Antibiotics (multiple ingredients)	9%	
Antibiotics, Total		32%
Minerals and Vitamins (one ingredient)	5%	
Minerals and Vitamins (mult. ingredients)	24%	
Minerals and Vitamins, Total		29%
Antihistamines, Cold and Cough Remedies	12%	
Hormones	7%	
Psychotropic Agents	4%	
Eupeptics and Tonics	4%	
Analgesics	4%	
Other	8%	
Subtotal		39%
GRAND TOTAL		100%
ALL MEDICINES WITH MULTIPLE INGREDIENTS		73%

Comment: An important question must be posed: who is served by these drugs and how well? A corollary question is: can more people be better served at the same or less cost? For example:

a) On a strict medical-scientific basis, in a country where beriberi, scurvy, and pernicious anemia are exceptionally rare, can the expenditure of large amounts of foreign exchange on vitamins B_{12}, B Complex, C and liver extract be justified?

b) Antibiotics are extremely necessary to the health of the people of Afghanistan. Should importation of expensive brand name and fixed combination of antibiotics be preferred to simple safe and inexpensive antibiotics?

c) Medicines with multiple ingredients have serious drawbacks. They are nearly always sold by brand-name, the cost of the drug is usually in excess of the sum of the ingredients taken singly; the ingredients are often below the necessary dosage for the condition they are intended to treat; and finally, problems of drug allergies multiply when multiple drugs are given. Does the GOA desire to use its scarce resources for such preparations?

These are hard questions involving medical, economics and even policy considerations. Adoption of a single generic formulary would go a long way to introducing lower cost, quality drugs relevant to the needs of the people.

ASSUMPTIONS MADE IN CONSTRUCTION OF A PROTOTYPE ANNUAL DRUG LIST FOR BASIC HEALTH CENTERS
(This list is only meant to demonstrate an approach to drug policy planning)

1. As a first approximation, assume a population of one million people prepared to go to 100 basic health centers on a regular basis for major and minor illnesses.
2. Demographic composition of that population is 200,000 people in the 0-4 age group; 100,000 in the 5-9 age group; 100,000 in the 10-14 group; 250,000 women 15-44 years old; 250,000 men 15-44 and 100,000 adults over 44 years old.
3. "Average" child weight taken as 10 kg. to calculate dosages.
4. The following diseases are anticipated in the various age groups based on surveys by Buck, MAP, UNICEF. Treatments are intended to be expeditious and effective. Nearly 90% of all potential illnesses coming to BHCs may be covered by this drug list.
5. Vaccines and family planning medicines are not included in the cost analysis as they are invariably part of other programs.

Illness	Age Group	Attack Rate	Drugs Used	Anticipated Volume Or Duration of Therapy Per Patient
1. Diarrhea				
	0 - 4	2 severe/year per person	Oral therapy in 100%	2 liters
			Ringer lactate in 10%	1 liter
			Tetracycline in 25%	3 days
			Metronidazole in 1%	3 days
	5 - 9	1 severe/year per person	Oral therapy in 10%	2 liters
			Ringer's in 1%	2 liters
			Tetracycline in 25%	3 days
			Metronidazole in 1%	3 days
	over 10	0.5 severe/year per person	IV + oral fluids in 1%	2 + 6 liters
			Tetracycline in 1%	3 days
			Metronidazole in 0.1%	3 days
			Kaolin in 100%	4 oz.
2. Otitis Media				
	0 - 4	1 bout/year per person	Procaine Aluminum Monostearate Penicillin G (PAM Pen G)	1 dose 300,000 u
			Triple sulfa	3 days
	5 - 9	0.5 bout/year per person	PAM Pen G	1 dose 600,000 u

Illness	Age Group	Attack Rate	Drugs Used	Anticipated Volume (Duration of Therapy Per Patient
12. Malaria				
	all ages	assume 5-10%	Chloroquine/Primaquine	3 day radical cure
13. Cutaneous Leishmaniasis				
	all ages	10%	Stibophen	one local injection
14. Leprosy				
	all ages	1,000 total	Dapsone	6 tab weekly
15. Malnutrition (Moderate)				
	0 - 4	5%	Multivits (A.D. folic, iron) food supplements	two weeks in winter season
16. Worms				
	0 - 4	100% ascaris 2.5% hookworm	Piperazine Tetrachlorethylene	4 tablets 1 cc
	5 - 9	100% ascaris 2.5% hookworm	Piperazine Tetrachlorethylene	4 tablets 1 cc
17. Urinary Tract Infection				
	0 - 4	5%	Triple sulfa	7 days
	5 - 9	1%	Triple sulfa	7 days
	over 10	2%	Triple sulfa	7 days
18. Anemia				
	all ages	7 - 10%	Iron tablets	1 daily 30 days
19. Conjunctivitis (including trachoma)				
	0 - 4	25%	Tetracycline eye ointment	1/2 oz.
	5 - 9	25%	Tetracycline eye ointment	1/2 oz.
	over 10	10%	Tetracycline eye ointment	1/2 oz.
20. Non-Specific Indigestion				
	over 5	2/year	Sodium bicarbonate	1-2 days
21. Constipation				
	all ages	3%	Milk of magnesia	1 oz.

Illness	Age Group	Attack Rate	Drugs Used	Anticipated Volume C Duration of Therapy Per Patient
22. Non-Specific Aches & Pains (head, back, etc.)	over 10	10/adult/year	Aspirin	20 per adult per yea (US consumption rate)
23. Severe Pain/ Trauma	over 10	2,000 yearly	Morphine	20 vials per BHC per year
24. Minor Surgery (Lancing boils, suturing lacerations)	all ages	20,000 yearly	Iodine Lidocaine	One ampule/procedure
25. Mild Agitation, Insomnia, Hypertension(mild)	over 10	?	Phenobarbital 1/2 grain	2,000 tablets per BH per year
26. Maternal Care		45,000 births yearly	1. A + D + folic + iron tab.	1 combination tab daily, 60 days.
			2. Tetanus toxoid	twice
			3. Ergot preparation	6-8 tablets
			4. Iron dextran for severe anemia (5%)	20 ml
			5. Family planning methods	donated

Illness	Age Group	Attack Rate	Drugs Used	Anticipated Volume Duration of Therapy Per Patient
3. URI				
	0 - 4	3 bouts/year per person	Phenylephrine Cough elixir	1/2 oz. 1 oz.
	5 - 9	2 bouts/year per person	Phenylephrine Cough elixir	1/2 oz. 1 oz.
	over 10	1 bout/year plus bronchitis per person	Phenylephrine Cough elixir	1/2 oz. 1 oz.
4. Exudative Tonsillitis				
	0 - 4	1/year/person	PAM Pen G	300,000 u
	5 - 9	0.25/year/person	PAM Pen G	600,000 u
	over 10	0.1/year/person	PAM Pen G	1.2 million u
5. Pneumonia				
	0 - 4	0.5 bouts/year per person	PAM Pen G Chloramphenicol	300,000 u 5 days
	5 - 9	0.1 bouts/year per person	PAM Pen G	600,000 u
	over 10	1%	PAM Pen G	1.2 million u
6. Asthma				
	0 - 4	0.1%	Epinephrine Aminophylline	in oil 7 mg/kilo
	5 - 9	0.1%	Epinephrine Aminophylline	in oil 7 mg/kilo
7. Tuberculosis				
	over 10	5% of population affected	INH/Thiacetazone Streptomycin in 1%	One year 3 months
8. Scabies				
	all ages	1% of population	Benzyl benzoate	2 oz.
9. Impetigo				
	0 - 10	5%	PAM Pen G	3-600,000 u
10. Tineasis				
	0 - 10	10%	Whitfield's ointment	1 oz.
11. Meningitis + toxic states (Typhus, Typhoid)				
	All ages	0.1%	Chloramphenicol	7-10 days

APPENDIX 4

ESTIMATED TOTAL AVAILABLE EXPENDITURE FOR HEALTH

AFGHANISTAN 1353

A crude outline of the annual national budget and/or expenditure in the health sector programs (Programs, Hospitals, Curative and Preventive Medicine, Drugs, Maintenance, Administrative, Training, Foreign Experts, Etc.) includes:

Ministry of Health		
Ordinary Budget (Afs. 200 Million)	$ 3,300,000	
Development Budget (Afs.112 Million)	1,850,000	
Total		5,150,000
Private Sector		
Imported Drugs	5,000,000	
Private Sector (at least conservatively, equal to the MOPH Budget, or- - - -)	5,000,000	
Total		10,000,000
International Assistance		
WHO	2,250,000	
UNICEF (**)	650,000	
WFP (**)	1,200,000	
I.P.P.F	125,000	
Total		4,225,000
Bilateral Assistance		
USAID	1,300,000	
Peace Corps	280,000	
CARE	370,000	
USSR (**)	800,000	
Other Bilateral Assistance	300,000	
Total		3,050,000
TOTAL	US	$22,425,000
Less Afghan Contribution to International Activities		1,000,000
GRAND TOTAL	US	$21,425,000

(**) Underutilized. Note that some funds from outside sources (marked with **) such as WFP and UNICEF, are substantially underutilized at present.

APPENDIX 5

PROBLEM/ACTION GUIDELINES FOR HEALTH CENTERS

The goals of educating health workers to care for various illnesses are:

1 to provide information that is readily learned and relevant to the patients' needs;

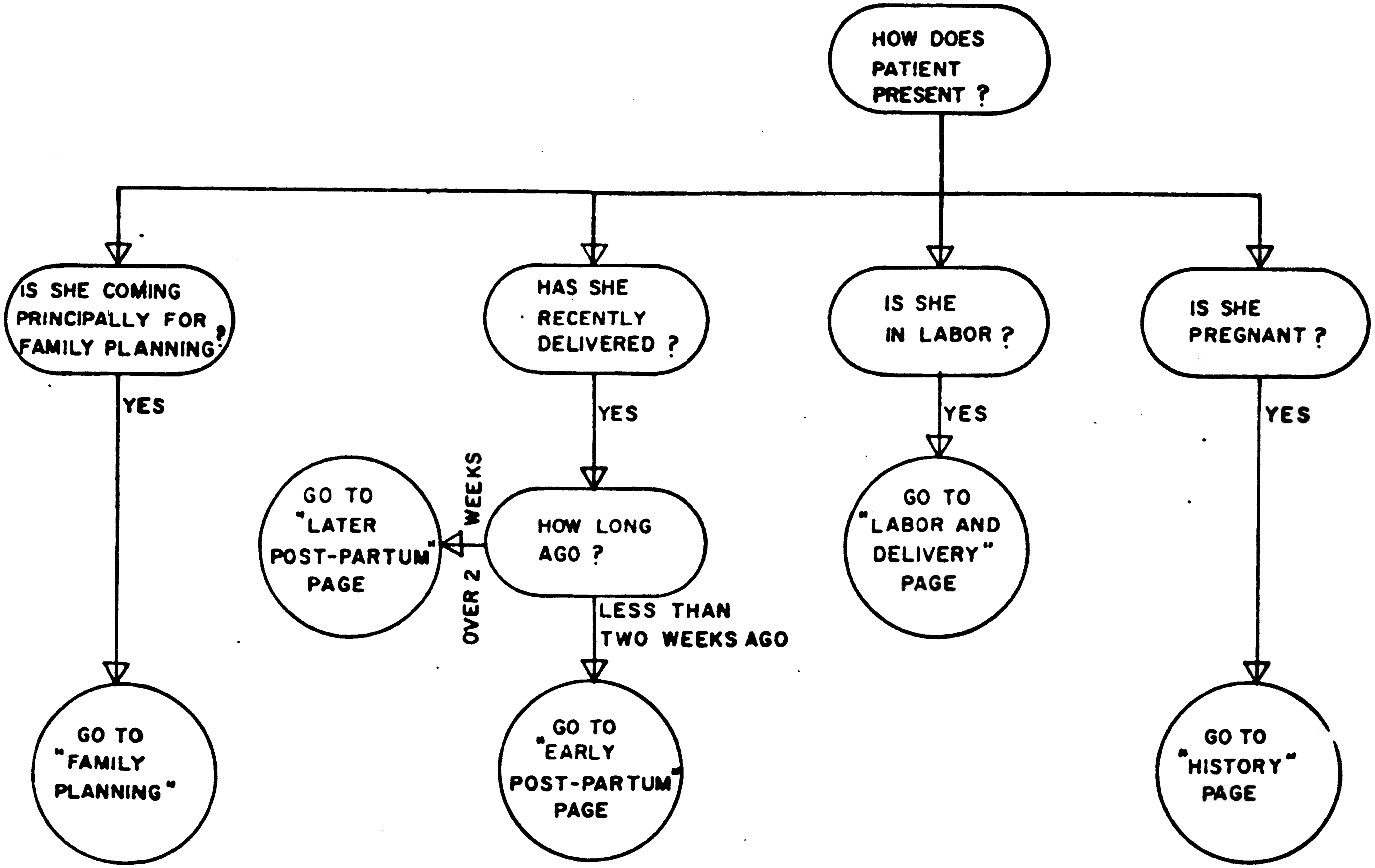
2) to provide an easily-used field guide;

3) to establish treatment regimens that are e fective, inexpensive and that lend themselves to supervision;

4) and to provide a basis for record keeping.

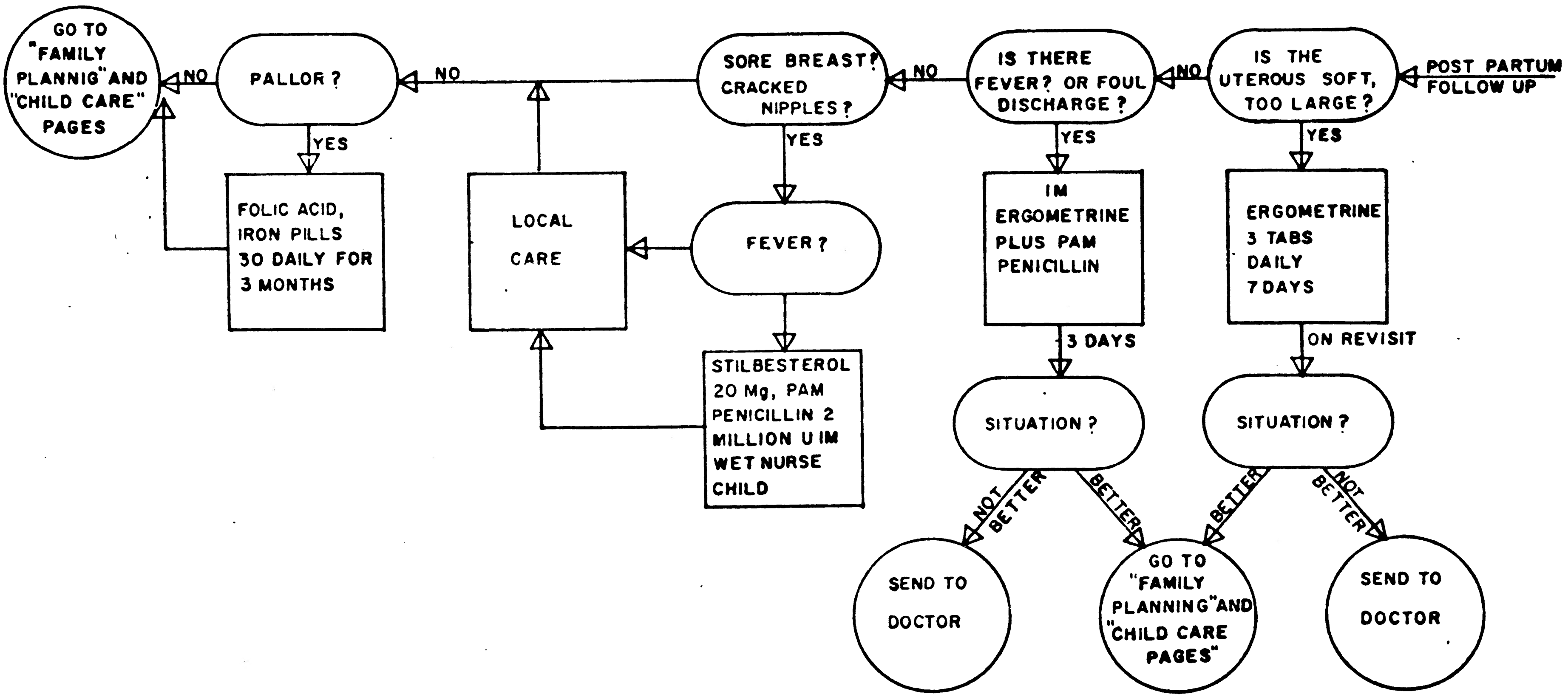
Problem/Action guidelines are a method proved useful in many US centers, India and Africa, and are used by physicians and non-physicians alike. This method takes the form of decision-tree flow charts which fulfill the four goals mentioned. As the technical health content of health worker manuals, charts for Maternal Care/Family Planning, and child care (diarrhea, cough, fever, nutrition and immunization) are being developed in the MOPH with WHO technical cooperation, and sample sheets are attached.

MATERNAL CARE



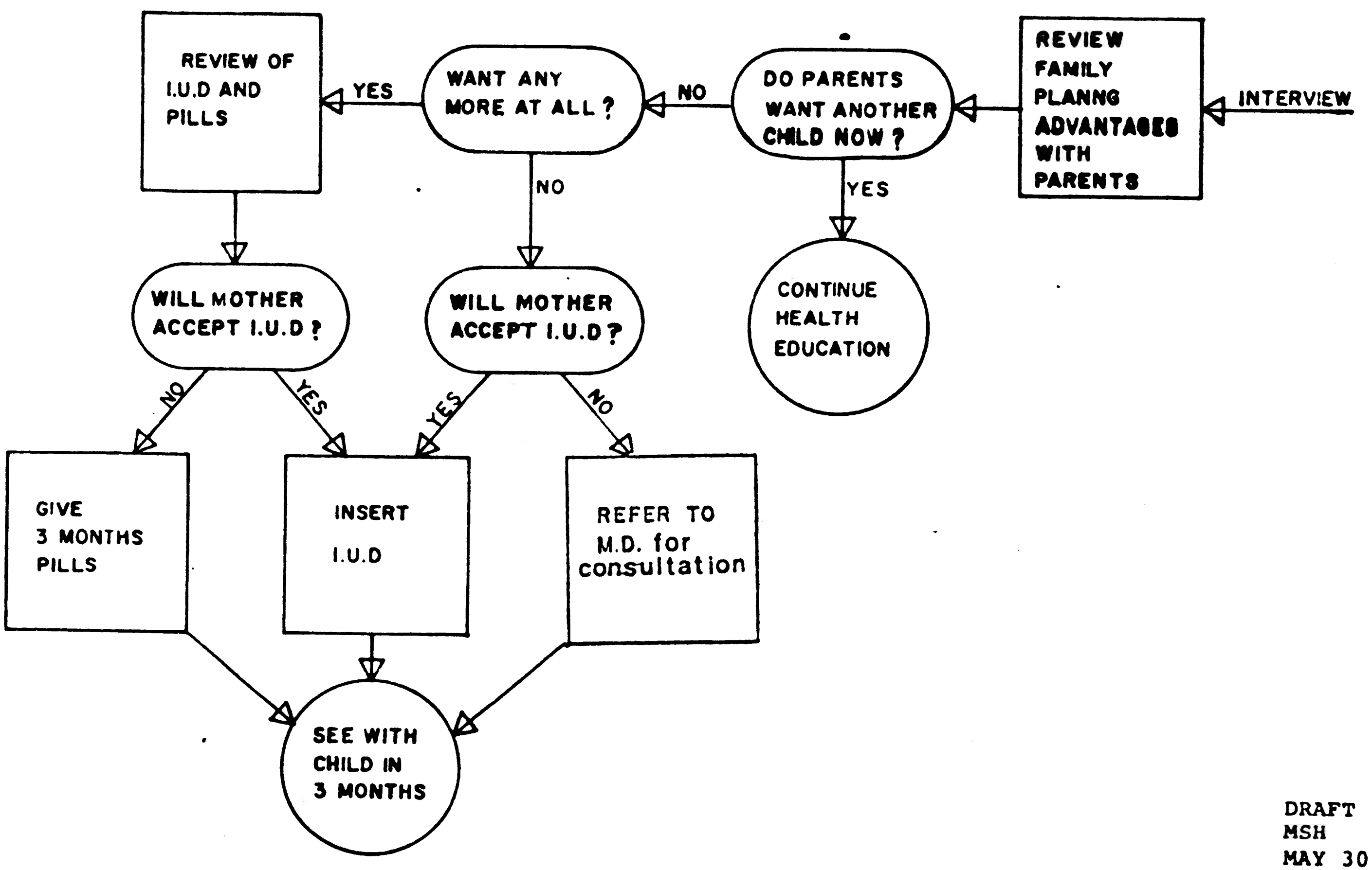
DRAFT
MSH
MAY 30, 1974

LATER POST-PARTUM



DRAFT
MSH
MAY 30,1974

FAMILY PLANNING



DRAFT
MSH
MAY 30, 1974